

Jefferson Ambulatory Surgery Center

2701 Lake Villa Drive Metairie, LA 70002 p: 504-274-3100 f: 504-274-3199

To Whom It May Concern:

Recent changes in healthcare laws are requiring that patients having a procedure performed in an outpatient facility are notified of their patient rights prior to the date of their procedure. Patient rights include patient notification of rights, responsibilities, filing a complaint, advance directive, and the knowledge of whether their physician has financial interests in the facility in which the procedure is being performed. Please review, sign, and bring the forms included in this packet with you on the day of your procedure.

Thank You,

Jefferson Ambulatory Surgery Center

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PATIENT NOTIFICATION

PATIENT RIGHTS:

The patient has the right to:

- Be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, economic, education, religious background, physical handicap, or the source of payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Know of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Receive a copy of a clear and understandable itemized bill and receive an explanation of his/her bill regardless of source of payment.
- Receive upon request, full information and necessary counseling on the availability of known financial resources for his /her care, including information regarding facilities discount and charity policies.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- The patient has the right to be advised as to the reason for the presence of any individual involved in his /her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility.
- In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.

- The patient's written permission will be obtained before medical records can be made available to anyone not directly concerned with their care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record within a reasonable time frame.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trails. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided it subjects will be contained in the medial record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate, thereof, of the continuing healthcare requirements following their discharge from the facility.
- Be informed if Medicare eligible, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.

PATIENT RESPONSIBILITIES:

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following facility policies and procedures.

JEFFERSON AMBULATORY SURGERY CENTER

CONDITIONS OF SERVICE / PAYMENT

I AUTHORIZATION AND CONSENT FOR TREATMENT : I voluntarily authorize and consent to examinations, tests, procedures and medical treatment by employees and agents of Jefferson Ambulatory Surgery Center, physicians and their designees, as deemed advisable in their professional judgment. I understand that risks may be associated with diagnosis and treatment, and acknowledge that no guarantees have been made to me regarding results of examinations or treatments. I hereby authorize the Facility to dispose of, at its convenience, any specimens, tissue, or parts taken from my body in accordance with customary medical practice.

II PERSONAL SAFETY: I am made aware that some patients are at heightened risk of suffering falls because of their physical or mental condition or medication. I am instructed and encouraged, and agree to call for assistance when needed and to keep the protective bedrails up as necessary to avoid falling.

III RELATIONSHIP BETWEEN THE FACILITY AND THE PHYSICIANS: All physicians furnishing services to the patient, including radiologists, pathologists, and anesthesiologists, are independent contractors with the patient and are not employees or agents of the Facility. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the Facility and its nursing staff to carry out the instructions of such physician. Charges for services by physicians are not included in the Facility bill, but are billed separately by or on behalf of the physicians.

IV FINANCIAL OBLIGATIONS: The undersigned patient and / or the guarantor hereby individually obligate himself or herself to pay the charges of the Facility in accordance with its regular rates within (30) thirty days of balance billing. If you are actively enrolled as a member of a group that is contracted with your provider of services, then the terms and conditions of the agreement between your provider and your group will supersede this billing policy. Upon request, we will mail an itemized bill detailing by category the services you received. However, if the patient is eligible to receive insurance or health plan benefits, the patient shall not be obligated to pay for services to the extent paid for pursuant to the insurance plan, but shall be responsible for any unpaid balance due. All delinquent accounts shall bear interest at the rate of one (1%) per month from the date payment is due.

V ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO FACILITY AND FACILITY BASED PHYSICIANS: I hereby assign and authorize direct payment of any insurance or health plan benefits otherwise payable to or on behalf of the patient for these outpatient services (1) to the Facility for charges at a rate not to exceed the Facility's regular charges, and (2) to the physicians who are Facility based or for whom the Facility bills for their professional services at a rate not to exceed such physicians regular charges. This assignment includes any attorney's fees, costs, and penalties payable by the insurance company for late payment of the benefits assigned. In accordance with Louisiana law (LA R.S.22:67) payment pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations during this visit, the undersigned hereby authorize the application of such excess funds toward any other outstanding account(s) which the patient may have for any prior services rendered or for which the undersigned is responsible. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

VI AUTHORIZATION TO RELEASE INFORMATION: I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid, the insurance company, health maintenance organization, workers compensation insurance, person acting on behalf of a preferred provider arrangement or any other named third party, when such information is requested for payment, workers compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing.

VII MEDICARE PATIENTS ONLY STATEMENTS TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER AND PHYSICIAN : I request that payment of all Medicare benefits be made on my behalf to the Facility for any services furnished to me by the Facility and for any physician services billed by the Facility, as well as radiologist and/or pathologist for their services. I authorize any holder of medical or other information about me to release to Jefferson Ambulatory Surgery Center and its agents any information needed to determine these benefits for related services.

VIII DISCLOSURE OF FINANCIAL INTERESTS: Pursuant to Louisiana Law, please note that certain Physicians may have a financial interest in Jefferson Ambulatory Surgery Center. If you are referred to this facility and have any questions, please discuss this with your physician directly.

CERTIFICATION: I certify that I have read this entire form, have had the opportunity to ask questions about it, have had them answered, and understand its contents. I certify that the information given to the facility is true, correct, and complete to the best of my knowledge.

Patient's Signature

Date

ADVANCE DIRECTIVE

PATIENT SELF DETERMINATION

What are Advance Directives?

Advance Directives are legal documents that let you give directions about your future medical care if you become so sick you can't make decisions. There are two types:

- **Durable Healthcare Power of Attorney** : A document that lets you give someone else - usually a close friend or relative - the power to speak for you and make decisions about your healthcare, if the time comes when you can't speak for yourself.
- **Living Will** : A document that lets you say what kinds of care you would or would not want if you were nearing the end of your life.

Do you have an Advance Directive?

No, I do not.

Do you have a copy with you?

Yes, I have (indicate which)

Living Will

Yes

No

Durable Healthcare
Power of Attorney (DHPOA)

Yes

No

Other _____

Yes

No

If no copy is provided at the time of admission:

I want to execute a new / duplicate Advance Directive.

It is your responsibility to provide the facility with a copy of your Advance Directive at the time of your visit so it can be placed in your medical record.

You are also responsible for notifying your attending physician of your Advance Directive.

The Facility's policy is to comply with your physician's order implementing Advance Directives.

Do you want help in executing an Advance Directive?

No, I do not.

Yes, I would like assistance.

Signature of Patient or Representative

Relationship to Patient

Date

Patient unable to make declaration; family members unavailable or have no knowledge of patient Advance Directive.

Signature of Admit Representative

Date

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL SECURITY # _____ DRIVERS LICENSE _____

MAILING ADDRESS: _____

CITY/STATE/ZIP: _____

HOME #: () _____ WORK #: () _____ CELL #: () _____

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

CITY/STATE/ZIP: _____

NEAREST RELATIVE OR EMERGENCY CONTACT PERSON

NAME: _____ PHONE: () _____

ADDRESS: _____ RELATIONSHIP TO PT: _____

NAME: _____ PHONE: () _____

ADDRESS: _____ RELATIONSHIP TO PT: _____

PRIMARY INSURANCE

INSURANCE COMPANY: _____

POLICY#: _____ GROUP#: _____

SUBSCRIBER'S NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S EMPLOYER: _____ OCCUPATION: _____

IF ACCIDENT OR INJURY RELATED - DATE OF INJURY OR ONSET:

IF WORK RELATED - EMPLOYER NAME: _____ PHONE #: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

POLICY#: _____ GROUP#: _____

SUBSCRIBER'S NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S EMPLOYER: _____ OCCUPATION: _____

I HEREBY DECLARE THE INFORMATION PROVIDED BY ME IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____

DATE _____

Place Patient Label Here

JEFFERSON AMBULATORY SURGERY CENTER

ANESTHESIA QUESTIONNAIRE PLEASE FILL OUT COMPLETELY

Patient's Name: _____

Date: _____ Surgeon: _____

Procedure: _____

Procedure Date: _____ Age: _____ Sex: M F

Height: _____ Weight: _____

Allergies: _____

Is this condition accident related? YES _____ NO _____ Date of Injury: _____

If not accident related, when did symptoms first occur? _____

Do you have any dentures, partials, bridges, plates, caps, crowns, loose or broken teeth?

List all surgical procedures you have had in the past: _____

List all medications / supplements that you are presently on: _____

If you are taking ANTI-COAGULANTS, BLOOD THINNERS, HERBAL SUPPLEMENTS, ASPIRIN OR VITAMINS, please answer the following questions:

Did you stop taking your medication? YES _____ NO _____
Name of medications: _____ Date Stopped: _____

Did you visit your Cardiologist/ Internist? YES _____ NO _____
Name of physician: _____ Phone #: _____

Did you have lab work, x-rays or EKG done? YES _____ NO _____
Where did you have labs, x-rays or EKG's? _____

If you are taking ANTI-INFLAMMATORY DRUGS please answer the following questions:

Did you stop taking your medication? YES _____ NO _____
Name of Medications: _____ Date Stopped: _____

Vital Signs:
B/P _____ Resp _____ Pulse _____ o2 Sat _____

Place Patient Label Here

Have you had or still have any of the following:		
	Medications Taken for Condition	
Cold in the last two weeks		yes no
Chronic Cough		yes no
Asthma		yes no
Tuberculosis		yes no
Emphysema		yes no
Shortness of breath		yes no
Any other lung problem		yes no
Do you smoke?	How much?	yes no
Rheumatic fever		yes no
Heart murmur / mitral valve prolapse		yes no
High blood pressure		yes no
Low blood pressure		yes no
Chest pain		yes no
Angina		yes no
Heart attack		yes no
Sleep apnea / Snoring		yes no
Do you use a CPAP?		yes no
Palpitations		yes no
Irregular heart beat		yes no
Fast heart beat		yes no
Anemia		yes no
Sickle cell disease		yes no
Sickle cell trait		yes no
Jaundice		yes no
Hepatitis		yes no
Liver disease		yes no
Slipped disc		yes no
Sciatica		yes no
Problems with hip		yes no
Problems with knees		yes no
Problems with back		yes no
Convulsions / Seizures		yes no
Stroke		yes no
Epilepsy		yes no
Polio		yes no
Paralysis		yes no
Meningitis		yes no
Thyroid problems		yes no
Diabetes		yes no
Low blood sugar		yes no
Kidney disease		yes no
Kidney Infection		yes no
Spastic muscles		yes no
Muscle weakness		yes no
Hernias		yes no
Stomach Problems / Gastritis		yes no
Ulcers		yes no

Place Patient Label Here

Have you had or still have any of the following:		Medications Taken for Condition	
Hiatal Hernia		yes	no
Reflux		yes	no
Colon problems / Colitis		yes	no
Diverticulitis		yes	no
History of psychiatric problems		yes	no
History of bleeding tendencies		yes	no
Blood Clots / Deep Vein Thrombosis		yes	no
Glaucoma		yes	no
Do you drink alcohol?	yes no rarely occasionally daily		
Do you or have you taken any social, street, or addicting drugs?	yes no what?		
When did you last take any social, street or addictive drugs?			
Are you allergic to tape, iodine, anesthetics, medications, latex or food?		yes	no
If yes, list your allergies:			
Are you allergic to bananas, avocados or kiwi?		yes	no
Have you or any blood relative had an unusual reaction to an anesthetic?		yes	no
If yes, describe reaction:			
Date of last menstrual period:	Pregnant ?	Breastfeeding?	
Do you have any venereal diseases?	yes	no	
Have you had a blood transfusion?	yes	no when?	
HIV	yes	no	
Do you have any prosthetic devices?	yes	no where?	
Do you have contact lenses on your eyes?	yes	no	
History of cancer?	yes	no	

To the best of my knowledge, I have answered the above questions truthfully and completely:

Patient's Signature: _____ Date: _____

Anesthesia Pre-Op orders:	Surgeon's Orders:	<input type="checkbox"/> waived
_____	_____	<input type="checkbox"/> waived
_____	_____	<input type="checkbox"/> waived
_____	_____	<input type="checkbox"/> waived
_____	_____	<input type="checkbox"/> waived
<input type="checkbox"/> NO TESTING REQUIRED	<input type="checkbox"/> Pre-op as ordered	
Other: _____		
Type of Anesthesia:	<input type="checkbox"/> Gen	<input type="checkbox"/> Ax Block
	<input type="checkbox"/> MAC	<input type="checkbox"/> Bier Block
	<input type="checkbox"/> Spinal	<input type="checkbox"/> Epidural
		<input type="checkbox"/> Local
		<input type="checkbox"/> Interscalene Block
		<input type="checkbox"/> Other: _____
Comments: _____		

Anesthesiologist: _____ Date: _____		

Place Patient Label Here