| DATE OF SURGERY | DOCTOR: | ACCOUNTS # |
|---|---|---|
| | | |

DURANGO
Outpatient Surgery Center
Affiliate of St. Rose Dominican Hospitals

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| PATIENT NAME (LAST) | (FIRST) | (M.I.) | SSN | | |
| DATE OF BIRTH | AGE | SEX | MARITAL STATUS | ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED ❑ DOMESTIC PARTNER | |
| HOME PHONE | CELL PHONE | EMAIL ADDRESS | | | |
| ADDRESS: | APT. # | CITY | STATE | ZIP | |
| PATIENT'S EMPLOYER (Responsible Party if patient is a minor or unemployed) ❑ F/T ❑ P/T | | EMPLOYER'S PHONE | DEPT / EXTENSION | | |
| EMPLOYER'S ADDRESS | CITY | STATE | ZIP | | |

## RESPONSIBLE PARTY INFORMATION

| | | | | |
|---|---|---|---|---|
| NAME (LAST) | (FIRST) | (M.I.) | SSN | |
| ADDRESS | APT. # | CITY | STATE | ZIP |
| RELATIONSHIP TO PATIENT | HOME PHONE | WORK PHONE | CELL PHONE | |

## EMERGENCY CONTACT

| | | |
|---|---|---|
| CONTACT'S NAME | RELATIONSHIP TO PATIENT | PHONE |

## INSURANCE INFORMATION

| | | | | |
|---|---|---|---|---|
| 1. PRIMARY INSURANCE CO. | | | PHONE | |
| CLAIM MAILING ADDRESS | CITY | STATE | ZIP | |
| INSURED'S NAME | PHONE | DATE OF BIRTH | SS | |
| RELATIONSHIP TO PATIENT | POLICY # OR ID # | GROUP # / GROUP NAME | EFFECTIVE DATE | |
| INSURED'S EMPLOYER | EMPLOYERS ADDRESS | | | |
| 2. SECONDARY INSURANCE CO. | | | PHONE | |
| CLAIM MAILING ADDRESS | CITY | STATE | ZIP | |
| INSURED'S NAME | PHONE | DATE OF BIRTH | I.D./SS | |
| RELATIONSHIP TO PATIENT | POLICY # OR ID # | GROUP # / GROUP NAME | EFFECTIVE DATE | |
| INSURED'S EMPLOYER | EMPLOYERS ADDRESS | | | |

## MEDICARE INFORMATION

| | | | | |
|---|---|---|---|---|
| MEDICARE NUMBER | RETIREMENT DATE | ARE YOU A VETERAN? ❑ Yes ❑ No | DID THE VA REFER TREATMENT? ❑ Yes ❑ No | HAVE YOU SUFFERED FROM BLACK LUNG? ❑ Yes ❑ No |
| ARE YOU ENTITLED TO MEDICARE BASED ON DISABILITY? ❑ Yes ❑ No | | ARE YOU ENTITLED TO MEDICARE DISABILITY SOLELY ON THE BASIS OF END STAGE KIDNEY DISEASE? ❑ Yes ❑ No | | |

## INJURY INFORMATION

| | | | |
|---|---|---|---|
| DATE SYMPTOMS BEGAN: ___ / ___ / ___ | WAS INJURY DUE TO ACCIDENT? ❑ Yes ❑ No | CAR? ❑ Yes ❑ No | WORK RELATED? ❑ Yes ❑ No |
| DATE OF INJURY: _____ / _____ / _____ | WORKMANS COMP. CARRIER | | |
| CLAIMS # | ADJ'S NAME | CARRIER PH # | |

**The physician does _____ or does not _____ have an investment in the Surgery Center. Please contact the physician if you desire further information.**

**PATIENTSIGNATURE** **DATE** **RESPONSIBLE PARTY SIGNATURE** **DATE** **REGISTERED BY INITIALS**

Last:
First:
ACT#:
DOB:

AGE:
DOS:

DURANGO
Outpatient Surgery Center
Affiliate of St. Rose Dominican Hospitals

## *FINANCIAL POLICY*

1. The patient is responsible for all charges incurred at Durango Outpatient Surgery Center (DOSC). A bill from DOSC for the use of the facility will be sent to the patient and /or the patient's responsible party. The charges on the bill cover the use of pre-op, operating and recovery rooms, medications, supplies, instruments, equipment and the facility staff. These charges do not include any professional physician fees for anesthesia, surgery, pathology, radiology, etc. and any pre-operative testing fees.

2. If you have insurance, DOSC will file a claim for you as a courtesy. If you have not been notified of payment from them my the sixth week following surgery, you should contact your carrier. If you have a deductible, co-pay, or co-insurance due, payment arrangements must be made prior to surgery. Any non-covered amounts, amounts over the usual and customary and compliance penalties will be billed to the patient.

3. DOSC has contracts with many managed care organizations. You are expected to follow the rules of your carrier in obtaining pre-authorizations, referrals, etc. DOSC will assist you with this process if needed and abide by all the rules of these contracts. If DOSC does not have a contract with your carrier, they will attempt to negotiate rates for your procedure with your insurance company/managed care organization but cannot guarantee the result.

4. If you do not have insurance, payment arrangements must be made prior to surgery. If requested, a price quote of charges for your procedure will be given. These quotes are based on averages and may vary significantly from actual charges because every patient's surgery is different. These quotations will not include any physician fees or services.

## *RELEASE OF INFORMATION*

5. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, DOSC may disclose portions of the patient's record, including his/her medical records to any person or corporation which is or may be liable for all or any portion of DOSC charges, including but not limited to insurance companies, health care service plans, workers' compensation carriers, the patient's employer, and utilization review monitoring organizations.

## *ASSIGNMENT OF BENEFITS*

6. I authorize direct payment to DOSC and to the full extent of my authority, I hereby assign to DOSC any insurance benefits otherwise payable to the patient or on the patient or on the patient's behalf for the patient's surgery, treatment or diagnostic procedure(s). It is agreed that payment to DOSC pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that the patient is financially responsible for charges not covered by this assignment.

## *FINANCIAL AGREEMENT*

7. I agree that payment for all charges incurred are the primary responsibility of the patient or the patient's responsible party. I authorize DOSC or its agent to check with any credit bureau, and to verify the patient's employment or insurance coverage. If the account is sent to any attorney for collection, the patient shall pay, in addition to all sums due, DOSC reasonable attorney's fee and collection expense. If any of my checks are returned by my bank, I understand that I will be charged an additional fee at the prevailing rate at that time.

8. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. I also understand that a photocopy of this release is as valid as the original.

Patient/Parent/Agent _____ Date _____ Time _____

Relationship to Patient _____ Witness _____

Last:
First:
ACT#:
DOB: AGE:
DOS:

# DURANGO OUTPATIENT SURGERY CENTER

## Patient Informed Consent to Resuscitative Measures

(Not Revocation of Advance Healthcare Directives or Medical Power of Attorney)

All patients have the right to participate in their own healthcare decisions and to make an Advance Healthcare Directive or to execute a Power of Attorney that authorize others to make decisions on their behalf, based upon their expressed wishes, when they are unable to make decisions or unable to communicate decisions. Durango Outpatient Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, Durango Outpatient Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk, but of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to your surgical risks, your expected recovery and care after your surgery.

Therefore, it is our policy (regardless of the content of any Advance Healthcare Directive, instructions from a Healthcare Surrogate or Attorney-in-fact) that if an adverse event occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Healthcare Directive, or Healthcare Power of Attorney. Your signature below does not revoke or invalidate any current Healthcare Directive or Healthcare Power of Attorney.

(If you do not agree with this policy, we are pleased to assist you to re-schedule this procedure.)

(Please check the appropriate box in answer to this question.)

**Have you executed an Advance Healthcare Directives Living Will or a Power of Attorney that authorizes someone to make Healthcare decisions for you?**

**Please initial appropriate answer(s):**

_____ Yes, I have an Advance Healthcare Directive, Living Will or Healthcare Power of Attorney.

_____ No, I do not have an Advance Healthcare Directive, Living Will or Healthcare Power of Attorney.

_____ I would like to have information on Advance Healthcare Directive.

By signing this document, I acknowledge that have read and understand the contents and agree to the process described above.

DATE: _____ Signature: _____
(Patient)

If consent to the procedure is provided by anyone other than the patient, the person providing the consent or authorization must sign this form.

DATE: _____ Signature: _____
(Patient Advocate)

Print Name: _____

Relationship to Patient:

- ❑ Court appointment guardian
- ❑ Attorney-in-fact
- ❑ Healthcare Surrogate
- ❑ Other: _____

_____
Durango Outpatient Surgery Center Employee

DURANGO
Outpatient Surgery Center
Affiliate of St Rose Dominican Hospitals

**INFORMED CONSENT TO RESUSCITATIVE MEASURES**

Last:
First:
ACT#:
DOB: AGE:
DOS:

## NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____

Name of Patient Signature of Patient

_____/ _____/ _____

Date Signed

_____ _____

Name of Patient's Personal Representative Signature of Patient's Personal Representative

_____/ _____/ _____

Date Signed

---

## FOR INTERNAL USE ONLY

_____ _____

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- ☐ Patient was unable to sign.
- ☐ Patient refused to sign.
- ☐ Other _____

_____

_____ - _____ (Version: As noted on NPP) _____/ _____/ _____ (Date: As noted on NPP)

**NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT**

Last:
First:
ACT#:
DOB: AGE:
DOS:

DURANGO
Outpatient Surgery Center
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# Patient's Communication Preferences Regarding their PHI

***Telephone Communication Preferences***

Home # _____

Work # _____

Mobile # _____

Other _____

Last:
First:
ACT#:
DOB: AGE:
DOS:

***E-Mail Communication Preferences***

Email Address _____

**In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs.** By providing the information above I agree that Magnolia Surgery Center or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Magnolia Surgery Center or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

_____

***Mail Communication Preferences***

May we send mail to your home address? ***(If no, please provide an alternate mailing address below.)***

_____

_____

***Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)***

| | Name: | Telephone |
|---|---|---|
| ☐ Spouse | _____ | _____ |
| ☐ Caretaker | _____ | _____ |
| ☐ Child | _____ | _____ |
| ☐ Parent | _____ | _____ |
| ☐ Other | _____ | _____ |

**I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.**

**I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.**

_____ _____

**Patient or Personal Representative Signature** **Date**

_____ _____

**Printed Name** **Relationship to Patient**

# PATIENT RIGHTS AND RESPONSIBILITIES

## PATIENT'S BILL OF RIGHTS:

1. A patient has the right to respectful care given by competent personnel.
2. A patient has the right, upon request, to be given the name of his attending practitioner, the names of all other practitioners directly participating in his care and the names and functions of other health care persons having direct contact with the patient.
3. A patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation,
examination and treatment are considered confidential and shall be conducted discreetly.
4. A patient has the right to have records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.
5. A patient has the right to know Durango Outpatient Surgery Center's rules and regulations that apply to his conduct as a patient.
6. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
7. The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
8. The patient has the right to full information in layman's terms, about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the responsible person.
9. Except for emergencies, the practitioner shall obtain the necessary informed consent prior to the start of a procedure.
10. A patient, or if the patient is unable to give informed consent, a responsible person, has the right to be advised when a practitioner is
considering the patient as part of a medical care research program or donor program, and the patient or responsible person, shall give informed consent prior to actual participation in the program. A patient, or responsible person, may refuse to continue in a program to which he has previously given informed consent.
11. A patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability or source of payment.
12. The patient who does not speak English shall have access, where possible, to an interpreter.
13. The patient has the right to expect good management techniques to be implemented within the Surgery Center. These techniques shall make effective use of the time of the patient and avoid the personal discomfort of the patient.
14. When an emergency occurs and a patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.
15. The patient has the right to examine and receive a detailed explanation of his bill.
16. A patient has the right to expect that the Surgery Center will provide information for continuing health care requirements following discharge and the means for meeting them.
17. The patient has the right to appropriate assessment and management of pain.
18. A patient has the right to be informed of his rights at the time of admission.

## PATIENT'S RESPONSIBILITIES:

1. The patient has the responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives and other matters relating to his/her health.
2. The patient has the responsibility to report unexpected changes in his/her condition to the responsible practitioner.
3. The patient has the responsible for reporting whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.
4. The patient is responsible for following the treatment plan recommended by the practitioner responsible for his/her care.
5. The patient is responsible for keeping appointments and, when he/she is unable to do so for and reason, for notifying the responsible practitioner or the Surgery Center.
6. The patient is responsible for his/her actions if he/she refuse treatment or does not follow the practitioner's instructions.
7. The patient is responsible for knowing their health insurance policy benefits with respect to outpatient surgery, including, but not limited to, co-pays, deductibles, required authorizations, referrals and policy limits. In addition, the patient is responsible for ensuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.
8. The patient is responsible for following the Surgery Center's rules and regulations affecting patient care and conduct.
9. The patient is responsible for being considerate of the rights of other patients and Surgery Center personnel, as well as being respectful of the property of other persons and of the Surgery Center.
10. The patient is responsible for following the smoking regulations of the facility.

Last:
First:
ACT#:
DOB: AGE:
DOS:

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# PRE-ANESTHESIA QUESTIONNAIRE

**INSTRUCTIONS:** Please indicate by a checkmark ( ✓ ) your answer to each question. These answers will greatly help us to give you the best possible care during your procedure. If you do not know an answer please indicate by a question mark (?). If there are multiple answers please circle the appropriate one, be specific, explain if necessary.

AGE _____ SEX _____ HEIGHT _____ WEIGHT _____

**MEDICATION ALLERGIES** _____ Reaction: _____

**ARE YOU ALLERGIC TO LATEX** ❒ Yes ❒ No Reaction: _____

Have you or anyone in your family had an unusual reaction to Anesthesia? ❒ Yes ❒ No Explain: _____

_____

Are you taking any blood thinning medications (aspirin, ibuprofen, plavix, coumadin, etc.) _____

Please list on medication sheet: _____

Are you taking any herbal medications? ❒ Yes ❒ No

Please list on medication sheet: _____

| Have you had or do you still have? When? | Yes | No |
|---|---|---|
| 1. Are you a diabetic? | ❒ | ❒ |
| 2. Do you have a cold? | ❒ | ❒ |
| 3. Bronchitis/or chronic cough? | ❒ | ❒ |
| 4. Sleep apnea/CPAP Machine | ❒ | ❒ |
| 5. Asthma? | ❒ | ❒ |
| 6. Emphysema? | ❒ | ❒ |
| 7. Shortness of Breath? | ❒ | ❒ |
| 8. Any other Lung Trouble? If yes, explain:_____ | ❒ | ❒ |
| 9. Do you smoke? How much _____ day? | ❒ | ❒ |
| 10. Rheumatic Fever? | ❒ | ❒ |
| 11. Heart Murmur? | ❒ | ❒ |
| 12. Any heart valve problems? | ❒ | ❒ |
| 13. High Blood Pressure? | ❒ | ❒ |
| 14. Do you have a pacemaker? Rate _____ | ❒ | ❒ |
| 15. Chest Pain/Angina? | ❒ | ❒ |
| 16. Heart Attack(s)? | ❒ | ❒ |
| 17. Palpitations: Irregular or fast heartbeat? | ❒ | ❒ |
| 18. Any Blood Disease? _____ | ❒ | ❒ |
| 19. Jaundice, Hepatitis, Liver Trouble? | ❒ | ❒ |
| 20. Gallbladder trouble? | ❒ | ❒ |
| 21. Do you drink alcoholic beverages? How much alcohol/beer in a week? _____ | ❒ | ❒ |
| 22. Gastric - esophageal problems? | ❒ | ❒ |
| 23. Reflux - frequent indigestion? | ❒ | ❒ |
| and /or Hiatal Hernia? | ❒ | ❒ |
| 24. Seizure Disorder? | ❒ | ❒ |
| 25. Neurological problems? | ❒ | ❒ |
| 26. Head or Neck injury or surgery? | ❒ | ❒ |
| 27. Back or disc problems or sciatica? | ❒ | ❒ |
| 28. Kidney Trouble? _____ | ❒ | ❒ |
| 29. Thyroid Trouble? _____ | ❒ | ❒ |
| 30. Any history of street drug use? | ❒ | ❒ |
| How long ago? _____ | | |

31. Have you had surgery before? Check or list below:

- ❒ Appendectomy
- ❒ Breast/Biopsy
- ❒ Cataracts
- ❒ Gallbladder
- ❒ Hernia
- ❒ Hysterectomy
- ❒ Orthopedic _____
- ❒ Sinus/Nasal
- ❒ Tonsils/Adenoids
- ❒ Other _____

32. Any illness or disease not listed? _____

Please list any information you feel would be helpful in your care:

Date: _____

Signature: _____

Print: _____

Last:
First:
ACT#:
DOB: AGE:
DOS:

# Medication Reconciliation Sheet



***Patient stated Home Medications (including herbal and over the counter drugs):***

**Allergies:**

| Medication | Dosage | Route | Frequency | Date | Time |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |

**The RN has reviewed and obtained all medication and doses to the best of the patient's knowledge.**

Reconciled by:

_____,RN

**Patient Signature**

**Date/Time**

DURANGO
*Outpatient Surgery Center*
Affiliate of St. Rose Dominican Hospitals

**Name:**
**DOB:**
**Phys:**
**DOS:**
**Sex:**

# Durango Outpatient Surgery Center

## Attestation for Procedure

Low Acuity Tier 1 non-urgent procedures & Intermediate Acuity Tier 2:

Patient Name: _____

During this time of precaution and public safety caused by the COVID virus, **I attest that I have self-monitored/isolated for symptoms of COVID-19 and that I am asymptomatic for the last 7 days prior to this surgery/procedure.** This will be signed day of surgery/procedure by patient only.

**For your safety + patients + their loved ones + our team:**

| Temp > 100.0 TEMP: _____ | Travel outside of state within 14 days? | Cough or Nasal Drip? Eye drainage? | Sore Throat? New stomach Upset? | Short of breath? Fatigue? | Chest Pressure or Headache? | Current Seasonal Allergies? Infections? | Loss of Taste or Smell? | Are you feeling OK? well or unwell? |
|---|---|---|---|---|---|---|---|---|
| o NO | o NO | o NO | o NO | o NO | o NO | o NO | o NO | OK |
| o Yes | o Yes | o Yes | o Yes | o Yes | o Yes | o Yes | o Yes | Not OK (get RN) |

---

Patient Signature: _____

Name: _____

Relation: _____

Phone # : _____

( ) Yes, Opt in for texting

( ) No

Last:
First:
ACT#:
DOB:

AGE:
DOS: