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PRE-PROCEDURE INSTRUCTIONS

- On the day of your procedure, you WILL NOT be able to drive yourself home regardless if you have IV sedation or not. Please make sure that you have a personal friend or relative sign out taking over your care and drive you home. ***You can not take public transportation home after your procedure such as: taxi's, buses, Uber etc...unless your are accompanied by your personal friend or relative.***

- You should refrain from eating **ANY** solid foods for 6 hours prior to your procedure (coffee with cream is considered solid food).

- You are ENCOURAGED to drink plenty of liquids (water, plain coffee, apple juice) UP TO 3 hours prior to your procedure to prevent unnecessary dehydration and possible difficulties in placement of IV access. NOTHING by mouth within 3 hours of scheduled procedure (Including gum, tic-tacs, or candy).

- If you are diabetic and on insulin, please DO NOT take your LONG ACTING Insulin (NPH) on the day of your procedure. You may continue the short acting Insulin (or sliding scale basis). If you are on oral medications for diabetes, do not take them on the day of your procedure. Please consult your physician if you have any questions.

- ***Patients on anti-coagulants(blood thinners), antibiotics, and anti-inflammatory medications*** **need to stop these medications. Please notify your physician for specific instructions if you are on these medications.**

  - ***All antibiotics should be completed at least one day before your injection.***

- Unless instructed otherwise, continue your regular scheduled medication with a small sip of water, especially blood pressure medication.
- Please **write all current medications on your paperwork** attached where specified.
- Fluoroscopy with X-ray radiation will be used during the procedure. ***Please make certain that the possibility of pregnancy has been ruled out for women at risk.***
- Please contact our office with any questions or concerns if your are unclear about your procedure instructions.
- Any "No Show" or "late" cancellation less than 24 hours will result in a $200.00 charge.

Print Name:_____ Scheduled date:_____

Sign:_____ Arrival time: _____
date

PRE-ADMISSION HEALTH QUESTIONNAIRE

Please fill out and hand to the receptionist when completed. The information on this sheet will be discussed with the nurse upon admission.

PATIENT ACCOMPANIMENT UPON DISCHARGE ADVISEMENT

For patient safety, you are hereby advised that it is the policy of Pain Care Providers Surgery Center ("PCPSC") that all patients who receive medical services, requiring anesthesia, be discharged in the company of an adult friend or family member "responsible adult sponsor".

PCPSC will make every attempt to accommodate your scheduled surgery and if you are not willing or able to provide the name and telephone number of a responsible adult sponsor to accompany you home following surgery, your surgery will be rescheduled to another date.

RESPONSIBLE PARTY DRIVING PATIENT HOME:	CONTACT NUMBER(S): 1. 2. Waiting in Lobby: ☐ Yes ☐ No

I HAVE RECEIVED, READ AND UNDERSTAND THIS PATIENT ACCOMPANIMENT UPON DISCHARGE ADVISEMENT

PATIENT SIGNATURE:	DATE:	TIME:
SIGNATURE OF DULY AUTHORIZED REPRESENTATIVE:	IF SIGNED BY OTHER THAN PATIENT, INDICATE RELATIONSHIP:	

PATIENT SELF ASSESSMENT

ALLERGIES to Drug / Medications (If Any):			**ALLERGIC TO LATEX:** ☐ Yes ☐ No
HEIGHT:	**WEIGHT(lbs):**	**Primary Care Physician or Internist:**	

LIST MEDICATIONS YOU TAKE CURRENTLY (including aspirin, natural herb supplements, diet pills):

	mg		**mg**		**mg**
	mg		**mg**		**mg**
	mg		**mg**		**mg**
	mg		**mg**		**mg**

LIST PREVIOUS SURGERIES OR PROCEDURES (including childhood):

PAST OR PRESENT HEALTH HISTORY (CIRCLE YES OR NO)

Health Issue		Explain	Health Issue		Explain
Stroke	Yes No		Headaches	Yes No	
High Blood Pressure	Yes No		Thyroid Disorder	Yes No	
Smoking: Year Quit:	Yes No		Prosthesis / Pacemaker	Yes No	
Lung Disease: Asthma / COPD	Yes No		Metal Hardware / Implant	Yes No	
Sleep Apnea-C-Pap	Yes No		Past Anesthesia Problems	Yes No	
Diabetes: Type I or II	Yes No		Bleeding Disorder	Yes No	
Heart Disease: Arrhythmia	Yes No		Recent Cold / Flu / Infection **Date:**	Yes No	
Recent Chest Pain/Heart Pain	Yes No		Glaucoma	Yes No	
Mitral Valve Prolapse	Yes No		Arthritis	Yes No	
Liver Disease	Yes No		Seizure Disorders	Yes No	
Hepatitis	Yes No		Acid Reflux- GERD	Yes No	
Cancer	Yes No		Current Pain: Location	Yes No	
Kidney Disease	Yes No		Other:	Yes No	
Immune Deficiency-HIV	Yes No		Pregnant: **LMP-Date**:	Yes No N/A	

PATIENT SIGNATURE:	DATE:	**If signed by other than patient, indicate relationship**

By signing below you are stating that the above information has not changed since your last visit to PCPSC.

PATIENT SIGNATURE:	DATE:	**If signed by other than patient, indicate relationship**
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PAIN CARE PROVIDERS SURGERY CENTER

PATIENT LABEL

CONSENT FOR ADMINISTRATION OF ANESTHESIA AND ANESTHESIA FINANCIAL AGREEMENT/ADVANCED BENEFICIARY AGREEMENT

There are risks involved in any type of anesthesia. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned anesthetic, the possible risks, complications and alternatives.

TYPES OF ANESTHESIA:

1. General Anesthesia – a loss of consciousness through the use of intravenous or inhalation gases which will cause unconsciousness during which patients are not arousable.
2. Regional Anesthesia – use of anesthetizing agents and or narcotics injected into the epidural space, subarachnoid space, or around nerves so as to produce a loss of sensation and or movement of a specific part of the body.
3. Monitored Anesthesia Care (MAC) – a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure. This may include the use of intravenous agents to produce various levels of sedation or analgesia.

RISKS AND COMPLICATIONS:

My anesthesiologist has explained to me the potential risks and complications of the types of anesthesia listed above. These risks include but are not limited to: allergic reactions, nausea, vomiting, headache, sore throat, infection, nerve damage, paralysis, muscle aches, dental damage, ocular injury, integument trauma, hematoma, aspiration, pneumonia, major internal organ injury, vocal cord/larynx damage, recall of sound/noise/speech by others during surgery (especially during lighter forms of anesthesia where recall may be considered normal), seizure, coma, stroke and death.

PREGNANT PATIENTS:

Anesthesia during pregnancy can cause fetal complications, birth defects, premature labor and fetal demise. The risks and complications mentioned above can occur to both the mother and the fetus. Non-emergent or elective procedures should be postponed until after delivery. If there is any possibility of being pregnant, I will inform the anesthesiologist and the surgeon.

ALTERNATIVES:

At your anesthesiologists' discretion, your original type of anesthesia discussed may be changed during your procedure as warranted for your safety and/or comfort. You have the right to postpone, cancel, or reschedule the procedure.

CONSENT:

I understand the types of anesthesia as described in this consent and discussed with my anesthesiologist as they pertain to my scheduled procedure. I am aware of the potential risks, complications, and alternatives. All of my questions have been sufficiently answered to my satisfaction. **I hereby consent to have the anesthesiologist named below provide the anesthesia for my procedure.**

The anesthesiologist is an independent contractor and is neither a servant, agent, nor employee of Pain Care Providers Surgery Center and therefore charges will apply separate from that of Pain Care Providers Surgery center and other physicians. In consideration of the services to be rendered to me, I hereby individually obligate myself to pay the amount in accordance with the regular rates and terms. As a courtesy, my insurance may be billed by my anesthesiologist. I understand that I am fully responsible for the charges and any balance not paid by my insurance carrier. Additionally, I understand if my insurance carrier determines that I do not qualify for coverage of anesthesia services for the procedure being performed on this admission based on medical necessity, coverage limitations, or any other reason, I will be fully responsible for the charges regardless of what my explanation of benefits from my insurance carrier states.

_____ _____ _____

PATIENT SIGNATURE DATE TIME

_____

IF SIGNED BY OTHER THAN PATIENT, PLEASE INDICATE RELATIONSHIP

_____ **M.D.** _____ _____

ANESTHESIOLOGIST SIGNATURE DATE TIME

_____ **M.D.**

ANESTHESIOLOGIST NAME

CONSENT FOR ANESTHESIA

Prior to the date of my procedure, I have received information in a language I understand and have been given the opportunity to ask questions about the following:

1. Grievance Process: Yes____ No____
2. Patient's Rights and Responsibilities: Yes____ No____
3. My Physician's ownership at Specialty Surgical Center: Yes____ No____

I have received information on the above that I did not receive prior to my surgery date.

Patient / Guardian / Responsible Adult:_____

Date:_____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, hereby acknowledge receipt of The Notice of Privacy Practices given to me by *Pain Care Providers Surgery Center.*

Signed:_____ Date:_____

For Office Use Only:
If not signed, reason why acknowledgment was not obtained:_____

Person seeking acknowledgment:_____ Date: _____

PCPSC	PAIN CARE PROVIDERS SURGERY CENTER		
	ORIGINAL DATE:	REVISED DATE:	PAGE NUMBER:
	SUBJECT: ADVANCE DIRECTIVE		NURSE MANAGER:
POLICY NUMBER:			MEDICAL DIRECTOR: Dr. Reza Mahrou Dr. Amir Rafizad

ADVANCE HEALTH CARE DIRECTIVE QUESTIONNAIRE

The Patient Self Determination Act became law in 1990. Information about "Your Right to Make Decisions About Medical Treatment" will be given to every patient during the registration process. In order to comply with this act, we ask the following questions:

Do you have an Advance Health Care Directive?	
YES	**NO**
What type? ❑ Durable Power of Attorney for Health Care ❑ Declaration to the Physician ❑ Living Will related to Health Care A copy of the advance directive has been received and placed in the chart. _____ (Registrar's initials)	The brochure "Your Right to Make Decisions About Medical Treatment" has been provided to me. _____ (Patient's initials) I would like to receive more information about Advance Health Care Directives. ❑ Yes ❑ No I have received additional information about Advance Directives as I requested above. _____ (Patient's initials)

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Patient Sticker

MANDATORY DATA COLLECTION FOR AMBULATORY SURGICAL CENTERS

Dear Patient:

As of January 1, 2005, the State of California, Office of Statewide Health Planning and Development ("OSHPD") mandates that ambulatory surgery centers collect individual encounter data (California Health and Safety Code, Division 107, Part 5 - Health Data, Section 128737). The data will be used for health planning projects, including:

(a) Management of state healthcare delivery and public health programs,
(b) Efficient administration of healthcare services,
(c) Continuous improvement in the quality of care provided by hospitals and ambulatory surgery centers,
(d) Effective procurement of healthcare services, and
(e) Identification and correction of disparities in healthcare access and outcomes.

Individually identifiable patient information is protected and encrypted within the State system.

In addition to the other information collected for the surgery, we also need you to select your race and ethnicity:

RACE:	**ETHNICITY**
R1 American Indian or Alaska Native	E1 Hispanic or Latino
R2 Asian	E2 Non-Hispanic or Non-Latino
R3 Black or African American	
R4 Native Hawaiian or Other Pacific Islander	
R5 White	
R9 Other Race	

If you have any questions, please contact the Patient Data Section of OSHPD at 916-323-7679. Additional information is available on the internet at www.oshpd.ca.gov/mircal

Thank you very much.

Patient Label Here

PCPSC

PAIN CARE PROVIDERS SURGERY CENTER

OWNERSHIP DISCLOSURE, ADVANCED DIRECTIVES AND GRIEVANCES

Who We Are

Dr. Reza Mahrou and Dr. Amir Rafizad have ownership interest in PAIN CARE PROVIDERS SURGERY CENTER, (PCPSC). Federal regulations require that we inform you in advance of the date of your surgical procedure. You may request that the surgical services provided be performed at some other alternative medical facility.

You're Rights as a Patient

You have the right to choose the provider and the facility for your health care services. You will not be treated differently by your physician if you obtain health care services at another facility.

Advance Directives

PCPSC DOES NOT HONOR ADVANCED DIRECTIVES. PCPSC will still document whether or not the individual has executed an advance directive. If you have an advance directive or living will, PAIN CARE PROVIDERS SURGERY CENTER will still transfer you to the closet hospital, which will make decisions about following any advance directive or living will. You have the right to be informed of our policy prior to the date of admission and if you have an advance directive PCPSC will include it in your medical record.

Advanced Directives are a set of processes by which decisions can be made for a person who for some reason is not currently able to make important health decisions for themselves. This is a legal document that has usually been made with an attorney, but any such document can be made with the signature of a witness who is a responsible adult.

Grievances

If patients have complaints or concerns in regard to their care at PAIN CARE PROVIDERS SURGERY CENTER, they are encouraged to notify the medical director and fill out a grievance form. You have the right go be free from any act of discrimination or reprisal. The staff at PCPSC acknowledges your exercise of right and respect for property and person and you have the right to be free from any act of discrimination or reprisal. You can request a copy of our grievance procedure.

Consumer complaints can be made at:

PAIN CARE PROVIDERS SURGERY CENTER
C/O Medical Director
Dr. (s) Reza Mahrou & Amir Rafizad
Phone: (949) 872-2400

AAAHC
5250 Old Orchard Rd, Ste 200
Skokie, IL 60077
Phone: (847) 853-6060

California Department of Health Services Orange County District Office
Phone: (800) 228-5234

The Medicare Beneficiary Ombudsman
800-MEDICARE
www.cms.hhs.gov/center/ombudsman.asp.

Please see the front desk for more information.

PAIN CARE PROVIDERS SURGERY CENTER

Notice of Privacy Practices (Protected Health Information)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

All patient information including but not limited to written, typed, faxed or electronic correspondence, billing, demographic and all medical records and charts will be physically and electronically protected in order to maintain patient privacy and confidentiality and to protect unauthorized access to that information.

All physicians and staff members will implement the following policies and procedures:

All patient information will be maintained in the medical record chart and the chart will be kept in a lockable file cabinet with lockable doors with limited key access.

Medical charts, notes, billing information, schedules and any other form of patient information will not be left within view of or accessible by unauthorized persons.

All physician and staff confidential conversations regarding patients are to take place, to the maximum extent possible, only in areas that cannot be overheard by unauthorized persons.

Computer data integrity will be maintained with firewall and virus protection software, regular back-ups of information and by limited access with password protection by only authorized personnel.

Patient medical information, photographs, or images will not be released without the written consent of the patient or legal guardian. Release of information for research, educational or diagnostic purposes will require the patient's written authorization.

Patient information may be released without prior consent for purposes such as: treatment, to report abuse, neglect, domestic violence, public health risks, to obtain payment for treatment, communication with family members if necessary, or to report reactions to medications or products.

Patients have the right to inspect and receive a copy of their medical records and to request an amendment to their records. Although the health care provider has the right to deny inclusion of an amendment, the patient has the right to file a "Statement of Disagreement" which will then become part of the patient's record.

Patients at this family are provided with this notice of privacy practices and will be asked to sign an acknowledgment will become part of the patient's medical records.

You are entitled to a complete copy of the Notice of Privacy Practices. Please see front desk for more details.

PAIN CARE PROVIDERS SURGERY CENTER
PATIENT RIGHTS

1. Exercise these rights without regard to sex, cultural, economic, educational, religious background, or the source of payment for care.

2. Patients of PCPSC are treated with respect, consideration, and dignity.

3. Patients are provided the appropriate privacy. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly, including the right of the patient to have auditory privacy for any discussion of his/her medical treatment at PCPSC.

4. The patient has the right to be advised as to the reason for the presence of any individual involved with his/her patient care.

5. Knowledge of the name of the physician who has primary responsibility for coordination of the care at PCPSC, as well as the names and professional relationships of other physicians and non-physicians who will be involved with the patient care.

6. Except when required by law, patient disclosures and records are treated confidentially, and written permission shall be obtained from the patient before the medical records can be made available to anyone not directly concerned with the care.

7. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, prognosis and prospect for recovery in terms that the patient can understand. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

8. Patients are given the opportunity to participate in decisions involving their healthcare at PCPSC, except when such participation is contraindicated for medical reasons.

9. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. This information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person(s) who will carry out the procedure or treatment.

10. Information is available to patients and staff concerning:
    a. Patient rights, including those specified above
    b. Patient conduct and responsibilities
    c. Services available at the organization
    d. Provisions for after-hours and emergency care
    e. Fees for services
    f. Payment policies
    g. Patient's right to refuse to participate in experimental research
    h. Methods for expressing grievances and suggestions to PCPSC
    i. Advance directives, if so requested by the patient
    j. Credentialing of healthcare professionals.

11. Patients are informed of their right to change primary or specialty physicians if other qualified physicians are available.

12. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

13. Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.

14. Patients will receive information in a format that they can readily understand. When necessary, an interpreter will be used.

15. Reasonable responses to any reasonable requests made for services.

16. Patients may leave PCPSC, even against the advise of Physicians, with a release.

17. Reasonable continuity of care and to know in advance the time and location of appointment, as well as the identity of persons providing the care.

18. Be informed of continuing healthcare requirements following discharge from PCPSC.

19. Patients have the right to have their pain assessed and treated promptly, effectively, and for as long as the pain persists. PCPSC shall insure that pain assessment is performed in a consistent manner that is appropriate to the patient.

20. Have all "Patients' Rights" apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

21. The patient has the right to the following:

    a. Be free from any act of discrimination or reprisal.
    b. Exercise of rights and respect for property and person.
    c. Provide feedback including complaints.

22. File a grievance. If you want to file a grievance with PCPSC, you may do so by writing or calling:

    Any patient having a grievance or complaint may address the issue with the following accrediting agency:
    AAAHC, 5250 Old Orchard Rd, Ste 200, Skokie, IL 60077-Phone 847-853-6060
    DHS-Dept of Health Services, Orange County, 800-228-5234
    The Medicare Beneficiary Ombudsman, 800-MEDICARE/website: http://www.cms.hhs.gov/center/ombudsman.asp.

PAIN CARE PROVIDERS SURGERY CENTER
PATIENT RESPONSIBILITIES

POLICY:

1. Patients have the responsibility to provide accurate and complete information about current and past illnesses, medications, supplements, over the counter products, allergies or sensitivities and other matters pertaining to their health.

2. Patients have the responsibility to follow the treatment plan recommended by their practitioner or express concerns regarding their ability to comply.

3. Patients are responsible for their actions if they refuse treatment or do not follow the practitioner's instructions. The patient must be respectful of all health care professionals, staff, and other patients in the facility. Patients have the responsibility to arrive as scheduled for appointments and to cancel in advance appointments they cannot keep.

4. Patients have the responsibility to become informed of the scope of basic services offered, change of provider if other qualified provider is available, the costs, and the necessity for medical insurance and to actively seek clarification of any aspect of participation in PAIN CARE PROVIDERS SURGERY CENTER services and programs (including cost) that is not understood.

5. The patient must accept personal responsibility for any charges not covered by insurance.

6. Patients have the responsibility to provide a responsible adult to transport him/her home from the facility and remain with him/her for twenty-four (24) hours, if required by his/her provider.

7. Patients have the responsibility to inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

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ANESTHESIA CARE SERVICES

It has come to our attention that some health insurance companies have started to deny coverage for anesthesia services rendered by an anesthesiologist during pain management procedures.

It is the position of Pain Care Providers that because of the chronic nature of pain in most of our patients and the potent medications frequently used to treat pain, anesthesia administered by an anesthesiologist who is not involved in perfoming the procedure and is solely concentrating on monitoring your vital signs; comfort, and depth of sedation; will ensure the highest level of safety.

Therefore, in order to avoid any misunderstanding and in the interest of full disclosure please choose one of the following options for sedation/anesthesia during your procedure:

☐ I would like the participation of an anesthesiologist for Monitored Anesthesia Care/MAC (moderate sedation) during my procedure. I understand that you will initially bill my insurance for anesthesia services that I receive during the procedures. However, If my insurance fails to cover these services; I agree to a discounted rate of $200.00 paid to Pain Care Providers; in order to cover anesthesia services.

☐ I do not desire the participation of an anesthesiologist during my procedure.

Signature_____Date_____

Patient Name: _____Date: _____

Questions to ask for procedures:

1. When was the last time you ate or drank? _____

2. Are you on antibiotics? Yes _____ No _____

   Are you taking aspirin? Yes _____ No _____

   Are you on blood thinners? Yes _____ No_____

3. Are you a diabetic? Yes _____No _____

4. Do you still menstruate? Yes _____ N/A _____ reason_____

Temp: _____
Blood Sugar: _____

Patient Signature: _____

MEDICATION RECONCILIATION

Name	Dose	How Taken	Resume Medication
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Physician Name

Physician Signature

Patient sticket here