TEL: 949 872 2400 | FAX: 949 872 2401 | WWW.PAINCAREPROVIDERS.COM

PRE-PROCEDURE INSTRUCTIONS

- On the day of your procedure, you WILL NOT be able to drive yourself home **REGARDLESS** of IV sedation. Please make sure that you have a friend or relative to sign you out and drive you home. ***You can not take public transportation home after your procedure such as: taxi's, buses, Uber, etc. ...unless you are accompanied by that friend or relative who signed you out.*** **Please do not bring valuables, this includes jewelry.**

- No solid foods for at least 6 hours (*or longer if you have acid reflux*) prior to your procedure (coffee with cream is considered solid food).

- You are encouraged to drink water **UP TO 3 HOURS** prior to your procedure – **UNLESS YOU HAVE ACID REFULX** - to prevent unnecessary dehydration. **NOTHING** by mouth within 3 hours of scheduled procedure (including gum, tic-tacs, or candy).

- If you are **diabetic**, do not take your morning dose on the day of your procedure. Please consult your physician if you have any questions.

- **Patients on aspirin and anti-coagulants (blood thinners) should notify for specific physician instructions.**

- **All antibiotics prescribed for NEW / CURRENT infections should be completed at least one day before your injection. Do not change your antibiotic schedule, if prescribed for long term prophylaxis.**

- Do not interrupt your routine **blood pressure and heart-related** medications at any time, **unless instructed otherwise.**

- Please **write all current medications on your paperwork** attached where specified.

- Fluoroscopy with X-ray radiation will be used during the procedure. ***Possibility of pregnancy will be ruled out for women at risk, using rapid test or infertility documentation.***

- Please contact our office with any questions or concerns if you are unclear about these instructions.

- Any "No Show" or "late" cancellation less than 24 hours will result in a $200.00 administrative fee.

Print Name:_____ **Scheduled date:**_____

Sign:_____ **Arrival time:**_____
date

- **YOUR POST-PROCEDURE FOLLOW UP IS ON:** _____
- **THIS FOLLOW UP IS MANDATORY FOR DOCUMENTATION AND INSURANCE PURPOSES.**

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): Reaction:			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):

SEE ATTACHMENT FOR MEDICATION LIST

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

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

Changes in Medication Yes_____ No ____

____ **No change in medication regimen postop.**

Physician Name

Physician Signature

Patient Sticker Here

CONSENT FOR ADMINISTRATION OF ANESTHESIA and SEDATION
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.

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.

_____ DATE _____ _____
PATIENT SIGNATURE TIME

_____
IF SIGNED BY OTHER THAN PATIENT, PLEASE INDICATE RELATIONSHIP

_____ M.D. _____ _____
ANESTHESIOLOGIST SIGNATURE DATE TIME

_____ M.D.
ANESTHESIOLOGIST NAME

CONSENT FOR ANESTHESIA

PAIN CARE PROVIDERS
SURGERY CENTER

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

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.

8. Patients must notify the treating provider if they hire an attorney, and they are involved in legation related to their pain symptoms.