2801 N W Mercy Drive, Suite 200
Roseburg, OR 97470
Telephone (541) 677-2800
Fax (541) 677-2820

Dear Patient,

Please carefully review the enclosed information and complete the PATIENT HEALTH HISTORY page and sign ALL enclosed paperwork. This information is very important for your surgery/procedure.

PLEASE NOTE that it is ORegon Surgery Center's policy that the parents, guardians, and family of patients 18 years old and younger and 60 years old and older ARE REQUIRED to remain at the Surgery Center during the procedure.

PLEASE BRING THIS PACKET WITH YOU TO YOUR SURGERY/PROCEDURE. If possible, please drop off this packet at ORegon Surgery Center as soon as you complete these forms.

If you have any questions about this packet, call ORegon Surgery Center's Pre-Op Clinic at 677-2828.

Important Information

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ORegon Surgery Center is designed to:

- Allow you to arrive, have surgery and go home the same day
- Be less expensive than surgery in a hospital
- Give you efficient, personal care in a pleasant atmosphere
- Allow a family member to be present in recovery areas

ORegon Surgery Center charges do not cover the professional service fees of your surgeon or assistant surgeon.

It may be necessary, in connection with your surgery, to include or perform certain other services such as:

- X-Ray or EKG
- Examination of tissue removed
- Administration of anesthetics and medications

If the services are deemed necessary, ORegon Surgery Center charges do not cover the service fees of the:

- Anesthesiologist
- Radiologist
- Pathologist
- Physician Consultant

Also, any services not directly related or incidental to your surgery are not included in the ORegon Surgery Center fee.

Additional Instructions:

____

____

Please leave children at home as our patients need a quiet environment.

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Insurance & Billing

1. If your surgery is covered by insurance, please bring a current insurance, Medicare or Medicaid card to ORegon Surgery Center

2. All charges are the patient's responsibility. As an added service to our patients, once coverage has been confirmed, we will bill the insurance company. Patient bills are due and payable within 30 days from date of billing. MasterCard and Visa are accepted.

3. The quoted fee is based on the scheduled procedure. In rare instances, unanticipated complications may cause the final fee to differ.

4. Cosmetic surgery fees are payable in full the day of surgery.

If you have any questions, please call ORegon Surgery Center at 677-2800.

Patient Rights

- To expect to be treated with respect, consideration and dignity.
- To be provided appropriate privacy.
- To expect that all disclosures and records are treated confidentially and released only with the patient's consent or when required by law.
- To be provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis.

Patient Responsibilities

- Accurately inform staff of correct billing address, phone number, age and social security number.
- Provide accurate information concerning health-related issues such as allergies, etc.
- Follow directions regarding medications and discharge instructions.
- Be on time for your scheduled appointment.
- Treat our staff with respect and decency.

ORegon SURGERY CENTER

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INSTRUCTIONS FOR YOUR SURGERY

Food or Drink: After midnight and until you have your surgery, you should have ***nothing at all by mouth unless*** you have been ***specifically instructed*** differently by your Surgeon or Anesthesiologist. This means no food, liquids, juice, coffee, tea, milk, or water. You may brush your teeth, but do not swallow any water.

Medications: ***Only take medication for your heart or blood pressure with one sip of water the morning of surgery***. (***If on insulin or diabetes pills – hold morning dose***.) **DO NOT TAKE ANY OTHER MEDICATION** ON THE MORNING OF SURGERY UNLESS INSTRUCTED TO DO SO BY YOUR ANESTHESIOLOGIST OR SURGEON.

For your safety, any exception to the "Food or Drink and Medications" instructions above must be approved prior to surgery by your Anesthesiologist. Your procedure may be rescheduled or canceled if these instructions are not observed.

The Day of Your Surgery: To make your Surgery Center visit as easy as possible, there are several things you should do ahead of time:

- Arrange for someone to drive you home after surgery
- Arrange for someone to be with you the first night after surgery
- Bathe or shower in the morning and wear clean, comfortable clothing that will fit easily over bandages. For knee surgery no jeans, for eye surgery no long sleeve shirt or blouse.
- Remove all makeup prior to arrival
- Leave watches, jewelry, metal body piercings, and credit cards or other valuables at home
- Bring a list of all your current prescription medications
- Bring all reports, X-rays, or papers given to you by your doctor
- If the patient is a child, do not forget to bring a favorite toy or blanket

Patients under the age of 18 should have a parent or legal guardian accompany them. The parent or legal guardian must sign the necessary forms and talk with the anesthesiologist. **If not the parent, the guardian must bring a copy of court authorization. We request that the parent or guardian remain at the Surgery Center during the surgery.**

- Bring your **insurance card, prescription card with you**.

If you are having foot, ankle, or knee surgery it is a good idea to bring crutches with you. You may purchase or rent them at most any local pharmacy.

Most prescriptions you receive may be filled at your regular pharmacy.

Your Arrival: A parking lot is available across from ORegon Surgery Center. You may drop the patient off in front drive-thru then park in the parking lot across the street.
For most procedures, we ask that you arrive 1 hour to 1 ½ hours before your scheduled surgery time. This time will be spent preparing you for surgery. Your doctor's office will give you an arrival time. **Please do not be late.**

To ensure your safety, **we require that you arrange for a ride home before your surgery**. If no one can drive you, call MMC Express #464-5555 to make reservations. Reservations must be scheduled prior to the day of surgery. If you have not planned for transportation home, your **surgery will be postponed or canceled until you have arranged for a responsible adult to drive you home**.

Anesthesia: Your anesthesiologist or your doctor will review your chart and determine with you the type of anesthesia best for you. Five types of anesthesia are commonly used for outpatient surgery: general, regional, IV sedation, local, and topical.

- **General anesthesia** is usually administered by adding medications to your IV and having you breathe a mixture of anesthetic gases.
- **Regional anesthesia** is administered by injecting medication around the main nerves to the affected area. This will produce numbness lasting from 1 to 4 hours. You may also be sedated during your surgery.
- **IV sedation** is administered by adding sedatives and medication to IV to induce sleep. This will be at the direction of your doctor.
- **Local anesthesia** is administered by injecting medication just under the skin to numb a small area.
- **Topical anesthesia** is administered by applying medication to the mucous membrane for surgeries involving the nose, throat, or bladder.

Your heart rate, blood pressure, oxygen concentration, and breathing will be monitored with special equipment throughout you operation, regardless of the type of anesthesia administered.

After Your Surgery: From the PACU (Post-Anesthesia Care Unit), or recovery room, you will be taken to the Phase II recovery area. Due to space limitations, only one visitor at a time is allowed in the Phase II recovery area. Both parents may accompany a child who has had surgery.

You will be discharged from ORegon Surgery Center when you are stable, and it is appropriate to go home. Depending on the procedure or surgery you had, you will be ready to leave anywhere from 30 minutes to 4 hours later.

Your Care at Home: When you are discharged, you will be given **written instructions** for your care at home. Be sure to follow your doctor's orders. Take pain medications as prescribed by your doctor. Follow a liquid diet for the first 6 hours following surgery, then advance to your regular diet. Once home you will need plenty of rest. **Arrange to have a responsible adult stay with you through the night.** If you have any **problems related to surgery or your procedure, call your doctor**.

Your Care at Home following Endoscopy: Take pain or other medications as prescribed by your doctor. Eat a regular diet, just not large amounts at first.

It will feel good to recover in your own home, but remember not to do too much too soon! For the first 24 hours following your surgery, regardless of how you feel,

- **DO NOT** drive a car or take public transportation by yourself
- **DO NOT** drink alcohol
- **DO NOT** sign legal documents or make important decisions
- **DO NOT** operate potentially dangerous equipment.

If you received local or topical anesthesia, you may return to normal activities without the 24 hour restrictions above. However, do follow the restrictions ordered by your doctor for your particular surgery.

You should receive a follow-up call from the Surgery Center nurse 1 to 2 days after your surgery. The Surgical Services nurse will be happy to answer any questions you may have about your postoperative care. In the mean time, call your doctor with any concerns or questions.

YOU SHOULD ARRIVE AT THE OREGON SURGERY CENTER ON:

Day ____________________ **Date** _____________________ **Time** ____________________.

PATIENT HEALTH HISTORY

OREGON SURGERY CENTER

DOCTOR'S NAME ______________________ SURGERY DATE ______________

EVALUATION:

1. If you are over 45, an electrocardiogram and certain laboratory tests may be required. Have these been scheduled?
   ☐ YES ☐ NO EKG done at ________________ LABS drawn at ______________
2. Height ________________ Weight _________________
3. Is your physical activity ever limited due to **shortness of breath** or **chest pain**? ☐ yes ☐ no Specify __________
4. Do you use Oxygen or a C-PAP machine at home? ☐ yes ☐ no __________
5. Have you or any member of your family ever had a **bleeding** disorder? ☐ yes ☐ no __________
6. Have you or any family member ever had a history of problems with anesthesia? ☐ yes ☐ no __________
7. Any **allergies** to medications or any unusual drug reactions? ☐ yes ☐ no
   Please list ____
8. **Do you smoke** or **Did you smoke**? ☐ yes ☐ no Packs/Day? _______How many years? _____Stopped_______
9. Do you drink alcohol every day? ☐ yes ☐ no If so, how much? ______________________
10. Do you take any medications regularly? ☐ yes ☐ no

MEDICATIONS	DOSE	FREQUENCY

MEDICATIONS	DOSE	FREQUENCY

INHALERS (bring them)

11. What pharmacy do you use? ____
12. Have you taken any aspirin, ibuprofen or **coumadin** in the last two weeks? ☐ yes ☐ no
    If so, how much? ______________ Does your surgeon know? ☐ yes ☐ no

Have you now or have you ever had?	**YES**	**NO**
Bleeding tendency	☐	☐
Blood clots in the legs	☐	☐
Cancer – list type ______________	☐	☐
Chest pain	☐	☐
Heart disease/Heart attacks/Heart surgery	☐	☐
Mitral valve prolapse	☐	☐
High Blood Pressure	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Kidney disease	☐	☐
Hiatal hernia/heartburn	☐	☐
Diabetes	☐	☐

	YES	**NO**
Implantable devices/pacemaker/defibrilator	☐	☐
Liver disease	☐	☐
Hepatitis B or C, or MRSA Bacterial Infection	☐	☐
Exposure to AIDS	☐	☐
Stroke/dizziness/blackouts	☐	☐
Seizures	☐	☐
Thyroid disease	☐	☐
Motion Sickness	☐	☐
Facial fractures	☐	☐
Recent cold/infection (circle one)	☐	☐
Dentures/crowns/caps (circle one)	☐	☐
Loose/broken/chipped teeth/jaw pain (circle one)	☐	☐

Have you been hospitalized in the last year? ☐ yes ☐ no If yes, why? ______________________

Do you have any significant illness or injury? ____________________________________

Do you have an Advance Directive/Health Care Power of Attorney? ☐ yes ☐ no

Females: Could you be pregnant? ☐ yes ☐ no Date of last period ________ Hysterectomy? ☐ yes ☐ no
Anesthesia in the 1st trimester can cause miscarriage. Test can be run if you are unsure. Please inform your admitting nurse.

Patient's Signature ______________________________ Date __________________

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ORegon Surgery Center

FACILITY INFORMED CONSENT

NAME OF PATIENT ______________________________ **ORSC NUMBER** ____________

I hereby consent to outpatient surgery, administration of drugs and solutions, laboratory studies, x-ray examinations or other medical or surgical treatment as may be rendered to ________________________ (myself or patient's name) under the general and special instructions of Dr. ______________________, his assistants or designees.

I understand that my care is under the control of my admitting physician(s) and that **in rare situations an anesthesiologist or radiologist may be requested to participate in my care without my express written permission**. **I fully accept such decision by my admitting physician(s).**

I understand that ALL DOCTORS AND DENTISTS FURNISHING SERVICES TO ME, INCLUDING THE ANESTHESIOLOGIST, RADIOLOGIST, AND PATHOLOGIST ARE INDEPENDENT CONTRACTORS AND ARE NOT EMPLOYEES OR AGENTS OF OREGON SURGERY CENTER.

IN CASE OF EMERGENCY PLEASE NOTIFY THE FOLLOWING FAMILY MEMBER

Name ____________________________ **Relationship** ______________________________

Tel. Number ______________________ **and/or Cell Phone #** ______________________

Signature of Patient or Authorized Person __________________________________

Relationship of Authorized Person to Patient ________________________________

Date Signed _______________________

Time Signed ______________________

Witness ____

PATIENT IDENTIFICATION

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ADDITIONAL PATIENT INFORMATION

Dear Patient:

The Department of Administrative Services, Office for Oregon Health Policy and Research requires ambulatory surgical facilities to report the following additional patient data as per ORS 414.021:

“(2) "Ambulatory surgery data" means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a surgical or diagnostic procedure treatment in a hospital outpatient setting or an ambulatory surgical facility setting into a data record.”

We appreciate your help in compliance with the above Oregon Revised Statute. Please put a check mark (✓) or circle the information that applies to you. This additional information as your other personal information is covered by the HIPAA Privacy Rule. Thank you.

CODE	**RACE DESIGNATION**
R1	American Indian or Alaska Native
R2	Asian
R3	Black or African American
R4	Native Hawaiian or Pacific Islander
R5	White
R7	Patient Refused
R8	Unknown
R9	Other
CODE	**ETHNICITY DESIGNATION**
E1	Hispanic or Latino
E2	Non-Hispanic or Latino Ethnicity
E8	Patient Refused
E9	Unknown

HIPAA (Health Insurance Portability & Accountability Act of 1996) ACKNOWLEDGEMENT AND CONSENT

I understand that ORegon Surgery Center referred to below as ORSC will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by ORSC, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that ORSC may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

A detailed **Notice of Privacy Practices** that describes the uses and disclosures of health information and the practices followed by ORSC staff and my rights regarding my health information is posted in waiting/reception area of ORSC for my perusal. I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of this Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that ORSC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I can have upon request a copy of the Notice of Privacy Practices.

By:____ Date:________________
(Patient)

-OR-

By:____ Date:________________
(Patient representative)

Description of Representative's Authority:____

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SURGERY CENTER

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Our Location