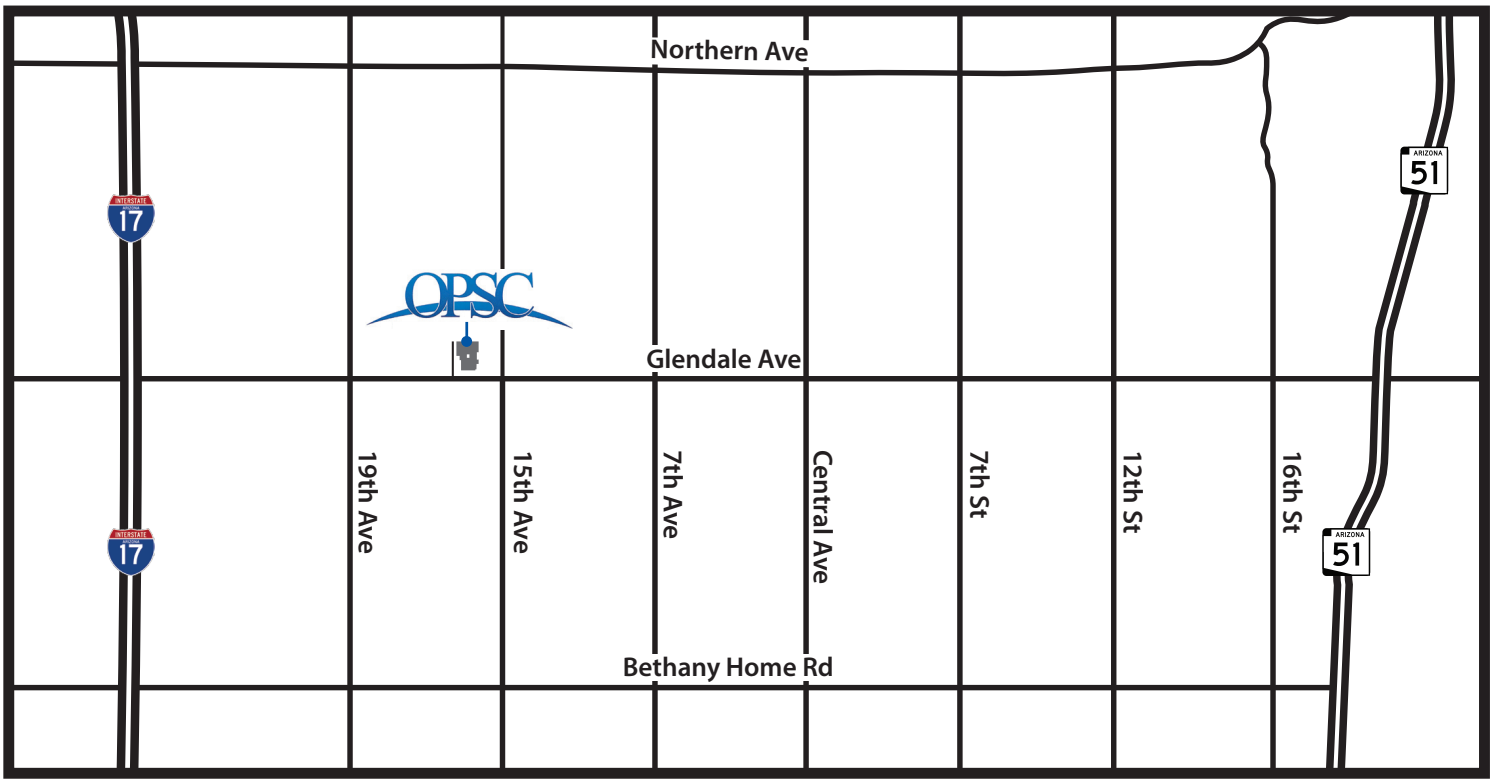
OUTPATIENT SURGICAL CARE, LTD.

High Quality Eye Care in a
Professional and Friendly Environment

1530 W. Glendale Ave Suite105 • Phoenix, AZ 85021
(602) 995-3395 • Fax (602) 995-1853



WELCOME

IMPORTANT:

PLEASE BRING THIS COMPLETED PACKET WITH YOU ON THE DAY OF SURGERY

OUTPATIENT SURGICAL CARE, LTD
1530 W. Glendale Ave. Suite 105
Phoenix, AZ 85021
602-995-3395

PACKAGE ACKNOWLEDGEMENT

Welcome! You have been scheduled to have your surgery at Outpatient Surgical Care (OPSC). Thank you for choosing our facility. We know you have a choice when it comes to your healthcare and we are grateful you chose OPSC. We know surgery can be a frightening experience and we are here to put you at ease. Please feel free to ask any questions along the way and be sure to have them answered in a manner by which you are comfortable.

Our AAAHC accredited and Medicare certified facility is equipped with state-of-the-art equipment to provide patients with the best quality of surgical care.

Attached is a packet of information that you will need to read, understand, complete and sign prior to your surgical visit with us.

- Preoperative instruction sheet
- Protocol for Advance Directives
- Notice of Privacy Practice (HIPAA)
- Statement of Patient Rights and Responsibilities
- Non-Discrimination Policy
- Limited English Proficiency (LEP)
- Grievance Process
- Statement of Physician Ownership
- Health History and Medication Reconciliation Forms

I acknowledge that I am in receipt of the above listed forms prior to my surgery and I understand it is my responsibility to read, understand, complete, sign and bring this completed packet with me on my surgical day.

Name_____

Address_____
City State Zip

Phone #_____

Social Security #_____ Date of Birth_____

Signature_____

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602-995-3395

Please check in at the reception desk upon arrival. To make your visit most comfortable please:

1. Stop eating all solid food 6 hours before surgery. You may drink clear liquids up to 2 hours prior to your scheduled surgery.

2. An RN from Outpatient Surgical Care will call you before your surgery to go over pre-operative instructions and verify arrival and procedure time.

3. **Bring your Insurance cards.**
4. **Bring a photo ID that includes your current address.**
5. **Be prepared to pay your deductible, co-payment, lens fee, and laser fee if applicable.**

6. Bring a copy of your Living Will and or Medical Power of Attorney, if you have one.

7. Leave all valuables and jewelry at home.

8. Wear loose fitting and comfortable clothing. Short sleeve shirt with a loose neckline is preferred.

9. Shower the night before or morning of surgery. Avoid using facial or eye makeup, moisturizers, and perfume the day of surgery.

10. Leave your dentures and hearing aids in place. You may be asked to remove your hearing aid if it is on the operative side.

11. Arrange for transportation. A responsible adult will need to drive you home. Please tell this individual to be prepared to wait approximately 2 hours. You should plan to have a responsible adult remain with you for several hours after your discharge.

OUTPATIENT SURGICAL CARE, LTD

References: AZ Administrative Rule: R9-10-909. Patient Rights
Accreditation Association for Healthcare, Patient Rights and Responsibilities

PROTOCOL FOR ADVANCE DIRECTIVES

1 Outpatient Surgical Care, Ltd, pursuant Arizona State Law requires their staff to recognize the statutory right of each competent adult patient to receive or refuse medical treatment. This decision may be in the format of Advance Directives for Health Care Decisions.
2 When an adult patient is unable to make or communicate treatment decisions, Outpatient Surgical Care must make a reasonable effort to consult with a surrogate.
3 Outpatient Surgical Care will not discriminate against a patient based on the existence or non-existence of an Advance Directive.
4 Any staff member of Outpatient Surgical Care unable to comply with this policy shall not prevent another staff member from complying with this policy.
5 Any attending physician who is unwilling or unable to follow the Advance Directive of a patient shall not delay nor impede the transfer of this patient to another physician who will follow the Advance Directive.
6 An unexpected medical emergency, occurring during the treatment at Outpatient Surgical Care, will be aggressively managed with stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal measures already begun in accordance with a patient wishes, advance directive, or health care power of attorney.
7 Prior to admission to Outpatient Surgical Care, each adult patient shall receive the following forms along with a verbal explanation:
   a. A written copy of Patient Rights at the facility.
   b. A written summary of Arizona State Law on Advance Directives.
   c. A written summary of Outpatient Surgical Care policy.
   d. An Advance Directive Acknowledgement to be signed by the patient and place in his/her medical record. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.
8 Advance Directives provided to Outpatient Surgical Care by a patient will become part of the patient's medical record. In addition, Medicare now requires an Ambulatory Surgical Center (ASC) to notify their surgical patients asking them to bring a copy of their Directives to the ASC. OPSC will request a copy of these directives to be brought to OPSC the day of their surgery. Documentation will be made in the patient's chart as to whether the patient complied; whether the patient will comply for future surgery; whether the patient has no interest in complying; whether the patient has no Advance Directives in place.
9 Any attempt to revoke an Advance Directive shall be honored.
10 Brochures on Health Care Directives will continue to be available to each patient/patient representative at OPSC to provide additional information and forms from state and federal organizations. This is also required by Medicare in their updated regulations.

OUTPATIENT SURGICAL CARE, LTD

STATEMENT OF PATIENT RIGHTS

Outpatient Surgical Care, Ltd. recognizes each patient as an individual with undeniable rights.

The patient has the right to:

- Be treated with consideration, respect, dignity, and individuality, including privacy in treatment and care for personal needs.
- To be treated without discrimination based on race, color, national origin, Limited English Proficiency (LEP), disability, or age during admission, treatment, or participation in our programs, services or activities.
- To be free from abuse, neglect, exploitation, seclusions, coercion, manipulation, sexual abuse, or sexual assault.
- To be informed of the proposed surgical procedures and the risks involved.
- To be told if the facility plans to engage in or perform human experimentation affecting his/her care or treatment and to refuse the participation in the project.
- To be included in decision regarding care and treatment and to request additional medical opinion regarding his/her condition and proposed treatment plan, communicated in words and terms the patient can understand.
- To receive assistance from family or representative to understand these rights.
- To refuse treatment, withdraw consent for treatment, give additional consent for treatment, or to leave the center against medical advice, after being informed of the medical consequences of his/her actions.
- To change providers if other qualified providers are available.
- To report any concerns regarding the quality of services provided during the time spent at OPSC and to receive prompt follow up for these comments.
- To access his/her medical records.
- To have medical and financial records kept in confidence. The release of these records shall be by written consent of the patient or patient representative except as permitted by law.
- To be informed of rates and charges prior to admission for services offered, or prior to a change in rates, charges or services, and advised of possible third-party coverage.
- To be advised on the facility's policy regarding advance directives.
- To be informed by OPSC physicians of any financial interest in OPSC.
- To submit grievances without retaliation by telephone or in writing:

  Administrator, Outpatient Surgical Care
  1530 W. Glendale Ave #105
  Phoenix, AZ 85021

- To file a complaint of suspected violations of health regulations and or patient rights:

  Arizona Department of Health Services
  150 N. 18th Ave.,
  Phoenix, AZ 85007
  602-364-3030 www.azdhs,gov

  Accreditation Association for Ambulatory Health Care (AAAHC)
  5250 Old Orchard Rd. #200
  Skokie, IL 60077
  847-853-6060 www.aaahc.org

  Office of Medicare Beneficiary Ombudsman
  www.medicare.gov.claims-and-appeals/medicare-rights/get-help/ombudsman.html

OUTPATIENT SURGICAL CARE, LTD

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability Act 1996 (HIPAA) is a federal program that requires all medical records and other identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. In 2009 and 2010 additional federal requirements were added known as HITECH (health information technology for economic and clinical health act). These requirements focus on business associates disclosing protected health information. Notification requirements include report to OPSC, to the US Department of Health and Human Services, and to you the patient. Civil monetary penalties for such infraction are based on the seriousness of the violation.

We may use and disclose your medical records for each of the following purposes;

Treatment means providing, coordinating, or managing health care related services by one or more health care providers. Example: a nurse or medical assistant obtaining medical information about you and recording it in your medical record.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. Example: sending a bill for your visit to your insurance company for payment.

Health Care Operations include the business aspects of running our practice, such as conduction quality assessment and improvement activities. Including auditing functions, cost-management analysis, and customer service. Example: internal quality assessment review.

…We may also create and distribute de-identified health information by removing all references to individually identifiable information.

…We may contact you to provide appointment reminders or information about treatment alternatives. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor that request except if we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

…The right to request restrictions on certain uses and disclosures of your health information to family members, relative, close personal friends, or any other person identified by you. We are, however, not required to agree to such a restriction. If we do agree to the restriction we must abide by it unless you agree in writing to remove it.

…The right to receive confidential communications about your health information from OPSC by alternative means, or from alternative locations.

…The right to inspect and copy your protected health information.

…The right to amend your protected information.

…The right to receive an accounting of disclosures of your protected health information.

…The right to obtain a paper copy of this notice form in unabridged text upon request.

…The right to file a written complaint regarding the handling of your health information.

OUTPATIENT SURGICAL CARE, LTD

NONDISCRIMINATION POLICY

Outpatient Surgical Care, LTD does not discriminate against any person based on race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact our compliance officer at (602) 995-3395.

Outpatient Surgical Care, LTD will provide interpreter services for communication with patients with Limited English Proficiency (LEP), visual or hearing-impaired, whenever it has been deemed necessary by the staff or has been requested by the patient. This service will be provided free of charge to the patient.

GRIEVANCE PROCESS

Policy: To comply with the revised regulations mandated by the Center of Medicare and Medicaid Services to meet the criteria for Medicare certification, effective May 18, 2009.

Procedure: The following guidelines will be followed regarding the implementation of any patient/family grievance as outlined in Outpatient Surgical Care's Patient Rights Policy.

Definitions: *Complaint*- dissatisfaction with services, outcomes, or systems, voiced or written.
Grievance- complaint that has not been resolved by manager or director, written complaints addressed to the grievance committee.

1. As a patient you have the right to file a complaint to the administrator at OPSC via telephone (602) 995-3395, or in writing to: Outpatient Surgical Care, Ltd. 1530 W. Glendale Ave #105 Phoenix, AZ 85021.
2. An aggrieved patient/family has the right to request in writing to OPSC, a formal hearing regarding the complaint within 90 days of occurrence.
3. The facility must respond to the parties' request within 30 days after receipt of complaint.
4. A formal meeting will be arranged within 45 days of this request and will include the complainant and the facility coordinator, with written minutes of the meeting documented.
5. Upon resolution, a summation of the agreement will be signed by the facility coordinator, dated, and mailed to the complainant who shall sign it within 15 days. A copy shall be placed in the patient's medical record and considered a binding and permanent solution.
6. If no resolution is achieved, the party may petition in writing within 30 days to the medical director of OPSC for a hearing.
7. A meeting will be arranged within 45 days of this request and consist of the medical director, facility coordinator, petitioner, and other involved parties to the grievance. The minutes of the meeting will be transcribed.
8. Resolution will result in a signed written agreement by all appropriate parties and become part of the permanent record of the patient.

HEALTH PROFESSIONAL REGULATORY BOARDS:

- AZ Dept. of Health Services, 150 N. 18th Ave, Phoenix, AZ 85007
- Accreditation Association for Ambulatory Health Care 5250 Old Orchard Rd Ste 200, Skokie, Il 60077
- Center for Medicare & Medicaid Services 7500 Security Blvd, Baltimore, MD 21244-1850

OUTPATIENT SURGICAL CARE, LTD

STATEMENT OF PHYSICIAN OWNERSHIP

We are required as an Ambulatory Surgical Center (ASC) to notify a patient if any physician has a direct interest in the ASC. The ASC must also notify the patient that the service is available elsewhere on a competitive basis. This disclosure allows the patient to make reasoned financial decisions concerning their medical care.

In compliance with the requirements, the following physicians have direct interest in OUTPATIENT SURGICAL CARE, LTD.

Dr. J. Shepard Bryan
Dr. Ray Zimmerman
Dr. Jay Schwartz
Dr. Gabriel Perry

ADVANCE DIRECTIVES

Outpatient Surgical Care is required by applicable Arizona State Regulations to make you aware of your right to be involved in decisions regarding your medical care at the time of service. Specifically, you have the right to execute an Advance Directive for Health Care Decision, i.e. "Advance Directive"; either in the form of a Living Will or a Durable Power of Attorney for Health Care. Information available for Advance Directive is available upon request.

I have executed an Advance Directive…… Yes _____ No____

Does it contain a **Do Not Resuscitate** clause…… Yes _____ No____

I would like information on Advance Directives…….. Yes _____ No____

I have a Living Will / Durable Power of Attorney for Health Care (circle appropriate)

Patient Name_____ Date_____

Patient Signature_____ Date of Birth_____

OPSC Representative_____ Date_____

OUTPATIENT SURGICAL CARE, LTD

PATIENT HEALTH HISTORY

Please bring this completed form with you on the day of your surgery

Name_____Age_____Weight_____Height_____ DOB:_____
Name of person taking you home_____Relationship_____
Contact Number for Driver_____

Please Check all that apply, Past or Present:

Heart/Vascular
___ Heart Attack(s) Date_____
___ Angina/chest pain
___ Irregular heart beat/murmur
___ High Blood Pressure
___ Heart Failure
___ Pacemaker (**Call Surgery Center for instructions**)
___ Mitral Valve Prolapse
___ Other_____

Lungs
___ Asthma/Wheezing
___ Emphysema
___ COPD
___ Bronchitis
___ Chronic Cough
___ TB (or family history)
___ Shortness of Breath
___ Sleep Apnea
___ CPAP machine use
___ Home Oxygen, Liters_____
___ Other_____

Genital/Urinary
___ Kidney disease
___ Renal Failure
___ Last Day of Dialysis
___ Other_____

Gastrointestinal
___ Liver Disease
___ Jaundice
___ Hiatal Hernia
___ Reflux
___ Other_____

Blood and Coagulation
___ Aids/HIV
___ Hepatitis Type: _____
___ Anemia
___ Bruising
___ Other_____

Nervous system
___ Stroke
___ Seizures/Epilepsy
___ Head/Neck Injury

Endocrine
___ Diabetes
___ Insulin
___ Thyroid Disease
___ Other_____

Musculoskeletal
___ Chronic back/neck problem
___ Arthritis
___ Multiple Sclerosis
___ Osteoporosis

Skin
___ Rashes/eczema/hives
___ Open wounds/sores/lesions

Other
___ Cataract Rt____ Lt____
___ Glaucoma Rt____ Lt____
___ Hearing Loss Rt____ Lt____
___ Cancer: Type_____
___ Recent cough/cold
___ Motion sickness
___ Dentures
___ Anxiety/Depression_____

Have you taken any anticoagulant/blood thinner or aspirin in the last 3 months? Yes _____ No _____
If Yes, name of drug: _____ For What: _____ Last dose:_____
Have you EVER taken the medication Flomax / Tamsulosin for prostate? Yes _____ No _____
Do you use tobacco? Yes_____ No_____ Quit When _____ Years of use_____
Do you drink alcohol? Yes_____ No_____ How many/week _____ Last drink _____
Lens Implants? Yes_____ No_____ Right _____ Left_____
Could you be pregnant? Yes_____ No_____ Last menstrual period_____

SURGICAL HISTORY (include eye surgeries): Procedures & Dates
_____
_____
_____

ANESTHESIA REACTIONS: Have you had any complication related to anesthesia? Yes _____ No _____
Describe reaction_____

_____ _____
Signature of Patient or Guardian Date RN Signature Date

Form completed by _____

Rev 12-2019

Updated with Patient Date **RN Initial**

OUTPATIENT SURGICAL CARE, LTD

MEDICATION RECONCILIATION FORM

PLEASE LIST ALL MEDICATIONS AND HERBAL SUPPLEMENTS TAKEN INCLUDING ALL AS NEEDED ITEMS:

ALLERGIES:

Allergy____________ Reaction____________ Allergy____________ Reaction____________
Allergy____________ Reaction____________ Allergy____________ Reaction____________

Name of Current Medications:	Dose:	Frequency:	Date Last Taken:	Reason for Taking:	Instructed to Hold on Day of Surgery:
		☐ daily ☐ twice a day ☐ as needed ☐ three times a day ☐ at bedtime			☐ Yes ☐ No
		☐ daily ☐ twice a day ☐ as needed ☐ three times a day ☐ at bedtime			☐ Yes ☐ No
		☐ daily ☐ twice a day ☐ as needed ☐ three times a day ☐ at bedtime			☐ Yes ☐ No
		☐ daily ☐ twice a day ☐ as needed ☐ three times a day ☐ at bedtime			☐ Yes ☐ No
		☐ daily ☐ twice a day ☐ as needed ☐ three times a day ☐ at bedtime			☐ Yes ☐ No
		☐ daily ☐ twice a day ☐ as needed ☐ three times a day ☐ at bedtime			☐ Yes ☐ No
		☐ daily ☐ twice a day ☐ as needed ☐ three times a day ☐ at bedtime			☐ Yes ☐ No
		☐ daily ☐ twice a day ☐ as needed ☐ three times a day ☐ at bedtime			☐ Yes ☐ No
FOR OFFICE USE ONLY					
New Medication Added After Surgery:	**Dose:**	**Frequency:**	**Route:**	**Reason for Taking:**	**Today:**
					☐ Yes ☐ No
					☐ Yes ☐ No

Copy given to patient upon discharge by: RN signature: __________________ Date: __________

Name: ____________________ **DOB:** ____________

Signature: ____________________ **Date:** ____________

Form Completed By: ☐ Patient ☐ Family