Patient Instructions

3333 W. Coast Highway, Suite 100
Newport Beach, CA, 92663
Phone (949) 645-6272 Fax (949) 335-9785

Patient Name:_____

Date of Surgery: _____ Morning/ Afternoon

1. **Do not eat or drink anything after midnight prior to your surgery.** If your surgery is after 2 pm, you may eat a light breakfast before 6 am.

2. A board certified anesthesiologist will discuss anesthesia options and answer questions, prior to your procedure. Most patients receive light sedation, or monitored anesthesia care (MAC) to assure comfort during surgery.

3. Ask your doctor about taking your routine medications; if permitted, take with a small sip of water only.

4. You must have a responsible adult drive you home after surgery, and be able to assist you for the first 24 hours. **You may not leave alone or drive yourself home. Your surgery will be cancelled if you have not made the necessary arrangements.**

5. Wear comfortable clothing the day of surgery. Slip on shoes or sandals. Short-sleeved button up or zippered shirts are preferable.

6. **Bring your insurance card(s), a photo ID and payment (if required) with you.** Leave your money, jewelry, and other valuables at home. However, if you wear dentures or hearing aids, they will not be removed unless necessary. **It is our policy to collect all applicable deductible, coinsurance and/or copay's on your date of service. You will receive a call the day before surgery to inform you of this amount. If you would like this information sooner, please call the business office at (949) 999-0152.**

7. A nurse will call you 1 day prior to surgery with the exact time. Plan to be at our facility for 2 hours. Your driver must stay at our facility unless they can be reached by cell phone.

8. **Bring the completed "Health History Questionnaire" and "Patient Notification and Acknowledgement" forms with you.**

9. Your surgeon requires the following tests prior to surgery:

Labs_____ EKG_____ NONE_____

<u>Please have your Primary Doctor fax a copy of the results to (949) 335-9785</u>

NEWPORT BAY SURGERY CENTER

Health History Questionnaire

Name: _____ **M / F** Age:____ Wt:____ Ht:_____

Do you wear? *(Circle one)*
Contacts: Y N **Dentures:** Y N **Hearing Aids**: Y N Left/Right/Both

Allergies to Medications: _____
(Please list)

Allergies to Foods, Tape, Soap, LATEX, etc._____
(Please list)

Current Medications (Prescription / Over-the-Counter / Herbal) – (*please attach list if necessary)*

Medication	Dose / Mg	X per day	Medication	Dose / Mg	X per day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
If yes, describe_____

Previous Surgeries/dates _____

Medical History *(Check all that apply to you)*

Cardiac
☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Irreg. Heart Beats
☐ Atrial Fibrillation
☐ Coronary Bypass #___
☐ High Blood Pressure
☐ Pacemaker

Lungs
☐ Asthma/Use Inhalers (Please bring your inhalers with you)
☐ Emphysema
☐ COPD/Use Oxygen at home?
☐ Bronchitis
☐ Allergies
☐ Sleep Apnea/Wear CPAP?
☐ Smoker, # Packs per Day

Thyroid
☐ Hyperthyroid
☐ Hypothyroid

Eyes
☐ Glaucoma ☐ Cataract surgery
☐ Retina surgery

Kidney
☐ Chronic Urinary Tract Inf.
☐ Dialysis, When_____
☐ Renal Failure

GI / Liver
☐ Hepatitis A,B,or C
☐ Cirrhosis
☐ Frequent Heartburn
☐ GERD/ Gastric Reflux

Diabetics
☐ Oral Meds
☐ Insulin Reg/NPH
☐ Diet Controlled

Central Nervous System
☐ Stroke/TIA's
☐ Seizures/Migraines
☐ Dementia/ Alzheimer's

Pregnancy Screen
☐ Possibility that you might be pregnant? If yes, please speak with your surgeon

Other
☐ Alcohol Use -How Often_____
☐ Drug Use -Specify_____
☐ Bleeding Disorders
☐ History of Mental Illness
☐ **Take / Have taken FLOMAX**
☐ History of Staph Infection

PATIENT STICKER

Patient / Guardian Signature:_____ **Date:**_____

There have been no changes to the above: _____ _____
Patient Signature Date

Notice of Privacy Practices

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.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of Protected Health Information (PHI).

The Law Requires Us to:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices and your right regarding your PHI.
- Follow the terms of the notice that is now in effect.
- Notify you if a breach in the security of your Protected Health Information (PHI) occurs.

We Have the Right to:

Change our privacy practices and the terms of this notice at any time, as long as they are permitted by law. This includes information previously created or received before those changes. Notification will occur if any important change is made, and will be available upon request.

Use and Disclosure of Your Protected Health Information (PHI):

The following section describes different ways that we use your PHI. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose PHI. We will not disclose any of your PHI for any purpose not listed below, without your specific written authorization. Any specific written authorization may be revoked at anytime by writing to us.

FOR TREATMENT: We may use PHI about you to provide you with medical treatment or services. We may disclose this information about you to doctors, nurses, technicians or other people taking care of you. We may also share your PHI with other health care providers to assist them in treating you.

FOR PAYMENT: We may use PHI to obtain payment for the services we provide.

FOR HEALTH CARE OPERATIONS: We may use and disclose your PHI for our health care operations. This might include quality improvement measures, evaluating performance of employees, staff training, accreditation, obtaining certificates and licensure that we need in order to operate. This also includes business management and administrative activities.

OTHER USES AND DISCLOSURES: As part of treatment, payment and health care operations, we may also use or disclose your PHI for the following purposes:

Notification: PHI used to notify or help notify a family member or other person responsible for your care. We will share information about your location in our facility, general condition and approximate wait time. If you are present, we will get your permission if possible, before we share this information. In case of emergency and/or if you are not able to give or refuse permission, we will share only the PHI that is directly necessary for your health care, according to our professional judgment to make decisions in your best interest.

Disaster Relief: PHI will be shared with a public or private organizations or persons who can legally assist in disaster relief efforts.

Fundraising: We may contact you to raise funds for the facility or an institutional foundation related to the facility. If you do not wish to be contacted, please contact our Privacy Officer.

Research in Limited Circumstances: PHI for research purposes in limited circumstances where the research has been approved by the Governing Body. They will review the research proposal and established protocols to ensure the privacy of your PHI.

Funeral Director, Coroner, Medical Examiner, and Organ Donation: We may disclose PHI of a person who has died with these entities in order to help them carry out their duties.

Specialized Government Functions: Subject to certain requirements, we may disclose and/or use PHI for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of the State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial Administrative Proceedings: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your PHI with law enforcement officials. We may share limited information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime or missing person. We may also share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your PHI to public health or official authorities charged with preventing or controlling disease, injury or disability, including suspected physical abuse, neglect or domestic violence. We may also disclose your PHI to the Food and Drug Administration for purposes or reporting adverse events associated with product defects, problems, tracking and other activities. We may also, when authorized by the law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

YOUR RIGHTS:

- The right to inspect and copy your PHI, via written request to the Privacy Officer. We may deny your request, if in our professional judgment, we determine that the access requested will endanger your life or another's.
- The right to request a restriction on uses and disclosures of your PHI.
- The right to request to receive confidential communications from us by alternative means or locations.
- The right to request amendments to your PHI in writing with reasons to support such a request. In certain cases, we may deny your request for an amendment.
- The right to receive an accounting of certain disclosures other for purposes of treatment, payment or health care operations. These written requests must be submitted to our Privacy Officer. Requests may not be for a period more than 6 years. We will provide the first request within any 12-month charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.
- The right to obtain a paper copy of this notice.

Contact Person:
Attn: Privacy Officer
Newport Bay Surgery Center, LLC
3333 W. Coast Hwy, Suite 100
Newport Beach, CA. 92663

The Privacy Officer can be contacted by telephone at 949-999-0152

This notice is effective September 15, 2007

Patient Notification and Acknowledgement

Notice of Rights

Newport Bay Surgery Center has established a Patient's Bill of Rights, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to the date of the procedure. Newport Bay Surgery Center expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the facility.

Financial Disclosure

Newport Bay Surgery Center is privately owned and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health related services.

Advance Directives

It is the policy of Newport Bay Surgery Center, regardless of any advance directives or instructions from a health care surrogate or power of attorney, that an unexpected medical emergency, which occurs during treatment at this facility, will be aggressively managed with resuscitative or other stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Please check the appropriate box. Have you executed an advance health care directive, a living will and/or a power of attorney that authorizes someone to make health care decisions for you?

☐ **Yes**, I have an advance health care directive, living will and/or a power of attorney.

☐ I have provided my advance health care directive, living will and/or a power of attorney to NBSC.

☐ **No**, I do not have an advance health care directive, living will and/or a power of attorney.

☐ I would like additional information on advance health care directives.

By signing this document, I acknowledge that the above information was given to me prior to my day of surgery, and that I have read and understand the information on notice of patient rights, financial disclosure and advance directives. I agree to the policies of Newport Bay Surgery Center. If I have indicated I would like additional information, I acknowledge receipt of that information.

_____ _____

Patient Signature (If patient is unable to sign, please indicate relationship) Date

_____ _____

Witness Signature Date

Patient Sticker