THE Surgery Center AT LONE TREE, LLC

PATIENT MEDICAL HISTORY

Allergies (please list):

_____

Please describe reaction to allergy/ allergies:

_____

Medications taken today:

_____

Are you on any?

Antibiotics: _____

Steroids: _____

Blood Thinners: _____

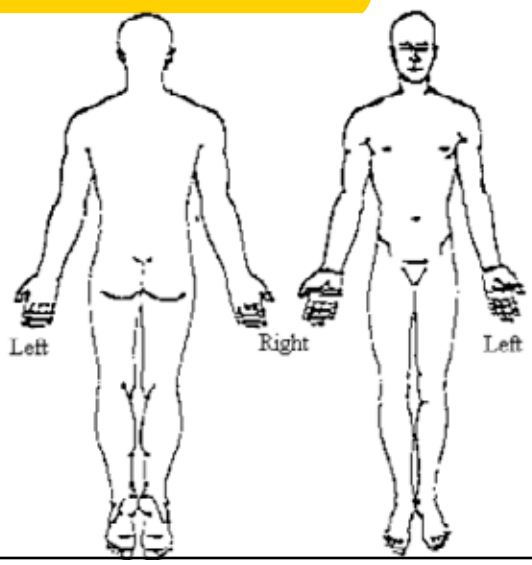
Date stopped: _____/_____/_____

Pain score on admission (1-10):

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

Please document the location of your pain on the right. -------->



Yes	No	CURRENT ILLNESSES AND DIAGNOSIS: Please respond to each question with the response that best describes you or the family member you are assisting. Has your doctor told you that you have any of the following conditions:
	○	Heart failure, heart attack, angina, chest pain, fainting
	○	High blood pressure (hypertension)
	○	Irregular heartbeat, heart disease, heart valve disease, mitral valve prolapse
	○	Pacemaker or Defibrillator
	○	Infectious Disease (HIV, Hepatitis, TB, etc.)
	○	Sleep apnea, lung disease, difficulty breathing. If "YES", please describe any supportive, respiratory device used (i.e. CPAP machine).
	○	Tobacco: How much? Packs/day How long? Years Months ○ Quit? Yes No ○
	○	Stroke, frequent headaches, neurologic disease
	○	Seizures, nervous disorder
	○	Diabetes
	○	Thyroid disease
	○	Liver disease, kidney disease
	○	Gastritis, heartburn, esophageal reflux, ulcer, hiatal hernia
	○	Cold, cough, asthma (wheezing)
	○	Drink alcoholic beverages: How much? Drinks a day ○ week ○ month How long? Years ○ Months ○
	○	Drug use (please specify):
	○	Arthritis, rheumatism, Where?
	○	Difficulty opening mouth or moving neck
	○	Chipped / loose teeth, dentures, special dental work
	○	Blood transfusion, bruising, sickle cell, clotting problems, bleeding
	○	Eye glasses, contact lenses, glaucoma
Please list any other medical conditions:		
Questions for females:		
	○	Is there a possibility you're pregnant?
	○	Are you breastfeeding?
	○	Have you ever had: Tubal Ligation Hysterectomy Menopause None

Patient signature: _____ Date: ____/____/_____

THE Surgery Center AT LONE TREE, LLC

LATEX ALLERGY QUESTIONNAIRE

(Patient Label)

After being exposed to latex, have you ever suffered from:			
	Yes	No	If yes, please explain:
Allergic Rhinitis		○	
Allergic Conjunctivitis		○	
Asthma		○	
Bronchitis		○	
Eczema		○	
Hay Fever		○	
Hives		○	
Sinus Problem		○	
Unexplained Rash		○	
Reactions to tapes/Band-Aids		○	
Have you ever reacted after Handling:			
Poinsettia plant		○	
Balloons		○	
Rubber products		○	
Clothing with elastic or stretch fabric		○	
Elastic bandages		○	
Have you ever had any of the following symptoms following a dental appointment:			
Itching		○	
Tearing		○	
Fatigue/drowsy		○	
Sneezing		○	
Runny nose		○	
Facial Swelling/redness		○	
Have you ever reacted after eating:			
Avocados		○	
Bananas		○	
Tropical fruit, kiwi, papayas		○	

Patient signature:_____ Date: ☐/☐/_____

Nurse signature:_____ Date: ____/____/_____

THE
Surgery Center
AT LONE TREE, LLC

PATIENT MEDICATION RECORD

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over- the-counter medications e.g. aspirin, antacids and herbals e.g ginseng, gingko biloba. Include medications taken as needed e.g nitroglycerin.

Date started	Name of medication/dosage	Frequency	Discontinue Date	Resume	Hold
_____/_____/________			_____/_____/________		
_____/_____/________			_____/_____/________		
_____/_____/________			_____/_____/________		
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_____/_____/________			_____/_____/________		
_____/_____/________			_____/_____/________		

(All medications listed above are written and provided by patient.)
Please let us know if there are any changes in your medications doses, frequencies, or discontinuations. Please initial and date below when medication record is updated.

Updated by:___/______,_______/______,______/_______,______/______,_______/______,______/_______,______/______,____/
Date: , , , , , , , , , , , , , ,

Patient Signature: ____ Date: _____/_____/______
Nurse's Signature: ____ Date: _____/_____/______
Physician Signature: ____ Date: _____/_____/______

Patient Label

THE Surgery Center AT LONE TREE, LLC

PATIENT CONSENT FORM

My initials below indicate that I have read, understood, and agree to the conditions identified herein:

Please Initial and fill out highlighted areas

_____ACCURACY OF PERSONAL INFORMATION

I have read the personal demographic information and it is current and accurate. I hereby agree to any and all changes that are in writing and indicated by my initials.

_____INFORMED CONSENT TO PROCEDURE AND OTHER MEDICAL SERVICES

I am having _____ procedure performed today by _____. (Surgery Center Staff will fill in this area)

1. The Surgery Center at Lone Tree Facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical, other diagnostic or therapeutic procedures. In general, such physicians, surgeons and practitioners are not agents, servants or employees of the Facility. They are Independent Contractors and; therefore, are the agent of you, the patient. The Facility provides nursing, support services and facilities and equipment. The facility does not provide the professional care components of the surgeon or physician.

2. My physician has explained the above listed procedure(s), the advantages and disadvantages, risks and possible complications, as well as the alternatives to me. The physician has answered my questions to my satisfaction.

3. I hereby give my consent to the procedure(s) with the understanding that any operation or procedure involves risks and hazards. The more common risks include, but are not limited to: infection(s), bleeding (with the possible need for a blood transfusion), nerve injury, blood clot, heart attack, stroke, and allergic reaction, damage to teeth or bridgework, and/or pneumonia. I understand that these risks can be serious and possibly fatal.

4. I hereby authorize and direct the above named surgeon to arrange for such additional health care services for me as he or she may deem necessary or advisable. These include, but are not limited to, the administration and maintenance of anesthesia, and the performance of pathology and radiology services, to which I hereby additionally consent.

5. I authorize the pathologist or physician to use his or her discretion in the disposing of any member, organ, implant, prosthetic, or other tissue removed from my person during the operation(s) or procedure(s).

6. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me for 24 hours following my procedure. I acknowledge that I have been advised by facility personnel not to drive during this same period. I understand this to mean that I should not drive until the day after my surgery/procedure or as further directed by my physician.

7. I hereby consent to the presence of other person(s) in the operating room, pre-op and/or recovery room for the sole purpose of observation and/or education. I understand that there individual(s) will not participate in the actual procedure.

THE Surgery Center AT LONE TREE, LLC

PATIENT CONSENT FORM

_____DISCLOSURE OF NPO STATUS

I hereby attest that I have not eaten any foods nor taken any fluids, not even water, since DATE: _____ TIME: _____ AM PM ○ *except for a sip of water taken with medication as instructed by my physician.*

_____DISCLOSURE OF OWNERSHIP INTEREST

I am aware that my physician may have a personal ownership interest in the Facility and that he or she may personally profit from that ownership interest. I acknowledge that I have a right to have the procedure performed at another facility. With this knowledge, I elect to proceed with my procedure at The Surgery Center at Lone Tree.

_____ADVANCE HEALTHCARE DIRECTIVES - LIVING WILL - HEALTH CARE PROXY

(Check below if not provided)

I understand that I have the right to makes choices regarding life-sustaining treatment (including resuscitative measures). I have provided the facility with a copy of my Advanced Directive, Living Will, or Health Care Proxy. The Facility's personnel have explained to me that it is the policy of this facility NOT to honor this document. In such an event, I understand that extraordinary measures will be used by the Facility's personnel to maintain and stabilize my vital signs until such time as I can be transferred to another healthcare facility with my Advanced Directive, Living Will, or Health Care Proxy. It will be the election of that facility and the legal system to fulfill the terms of these documents. With this knowledge, I agree to proceed with the proposed procedure as scheduled.

No, I did not provide the Facility with a copy of my Advanced Directive, Living Will, or Health Care Proxy.
Yes, I have an Advanced Healthcare Directive, and have provided the Facility with a copy.

_____FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL RECORD(S)

A photo static copy of this agreement shall be considered as effective and valid as the original. I irrevocably agree that the Facility may disclose, to the extent allowed by law, my medical and financial records to (a) any affiliate of the Facility, specifically, its employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the Facility or to me, or any person or entity responsible for all or part of the Facility charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the Facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services on me, including his or her employees and agents; (e) the Centers for Medicare and Medicaid Services and any other governmental or accrediting agency, or their agents or employees.

I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of services) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment.

_____FISCAL RESPONSIBILITY

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amounts when and as due. Facility employees are NOT able to define my insurance coverage. If I have coverage questions, I am advised to call my insurance carrier.

_____PATIENT BILLING PROCEDURES

Deductibles and co-payments are due and collectible on the day of service. Following my surgery, the physician performing my procedure will bill my insurance company for his/her services. If an anesthesia care provider participated in my treatment, whether I elected sedation or not, my insurance company will be billed separately for his/her services as well. Finally my insurance company will receive a bill from The Surgery Center at Lone Tree for my procedure; i.e., the use of the facility and nursing staff. After billing my primary insurance carrier, any secondary insurance will be billed. I will then be responsible for the payment of amounts not paid by my primary or secondary insurance carriers.

The Facility may not currently participate with all insurance companies. Since opening, the Facility has been working with companies to participate as a network provider. However until contract negotiations have been completed, the services provided to me may be considered "out-of-network". If the Facility is not "in-network" with my insurer, then I must have "out-of-network" benefits with my insurer to be scheduled as an insurance patient at this Facility. In the event that I have "out-of-network" benefits, the Facility will evaluate and decide whether to accept payment from insurance on a case- by-case basis. In circumstances in which the Facility is in negotiations with my insurer, the Facility will generally only request payment of the "in-network" co-payment and deductible from me at the time services are preformed. For my convenience of the patient, the facility may adjust from the bill any difference between the "out-of-network" and "in- network" obligations, provided my insurer does not object.

The Facilities billing department will forward a final bill to me for any co-payments, deductibles, or payments due once appropriate adjustments have been made. I will receive a separate bill from the physicians or other independent service providers.

If I have no insurance, the Facility will offer a discount from the normal billed charges (excluding the cost of implants or equipment) for cash payment at the time of service. Payment arrangements may be made in advance at the request of the patient or doctor.

_____TRANSLATION SERVICES

If I do not speak or understand English, I understand that the SCLT will provide me with a translator. If I choose to bring my own translator, I am aware of the loss of confidentiality regarding my care and possible communication difficulties if my translator has limited medical experience.

_____NOTICE OF PRIVACY PRACTICES

The Surgery Center at Lone Tree will use and disclose my personal health information to treat me, to receive payment for the care provided, and for other health care operations. Typical entities include, but are not limited to:(1) transporting emergency medical service providers, (2) healthcare providers rendering current care, (3) organ or tissue procurement agencies, (4) prospective healthcare providers, (5) facility employees for quality assurance, peer review, accreditation or certification compliance, (6) governmental oversight agencies (7) third party payers to facilitate reimbursement, (8) court order or subpoena. Health care operations generally include those activities performed by the Facility to improve the quality of care. The Facility has NOTICE OF PRIVACY PRACTICES and PATIENT RIGHTS to help me better understand their policies in regards to my personal health information. The terms of the notice may change with time and will always post the current notice at the Facility and have copies available for distribution. I hereby the Facility acknowledge receipt of this information.

THE Surgery Center AT LONE TREE, LLC

PATIENT CONSENT FORM
AUTHORIZATION TO RELEASE PATIENT DIRECTORY INFORMATION (Choose ONE option below)

☐ **OPTION 1: RELEASE OF PATIENT DIRECTORY INFORMATION:** I hereby agree to the release of patient directory information as permitted by state and/or federal law. (Directory information is the acknowledgement of the presence of the person receiving, outpatient services, their location within the Facility, and the patient's general health status described in terms of "good", "fair", "critical", or "expired". State law allows the release of patient directory information without the patient's written authorization unless the patient instructs otherwise or the information is protected by state or federal law.) I have listed below the authorized individuals that may receive patient directory information about me. Any attempts at contact from individuals not listed below will be re-directed in accordance with privacy practices.

_____

Name (transportation agent) Relationship Phone Number

_____

Name Relationship Phone Number

☐ **OPTION 2: NO RELEASE OF PATIENT DIRECTORY INFORMATION:** I do not authorize the release of any information regarding my admission or treatment to any requestor. (Admission will not be acknowledged). I wish to be a "no information" patient. I understand that as a "no information" patient any telephone calls, flowers, mail, or visitor inquiries (including family) regarding my stay will be addressed by stating, "We have no information to release". This option, however, does not preclude this Facility from providing patient healthcare information to those entities specified by law and as outlined in the Facility's Notice of Privacy Practices above. This authorization is valid for a period of time necessary to complete all transactions related to this treatment from the date of signature.

SIGNATURE

My signature below constitutes my acknowledge that (1) I have read or have had read to me the foregoing, and I agree to it; (2) the procedure(s) has been adequately explained by my physician; (3) I authorize and consent to the performance of the procedure(s) and any additional procedure(s) deemed advisable by my physician in his or her professional judgment; (4) I authorize and consent to the administration of anesthesia for the said procedure(s). If I am not the patient, I represent that I have the authority of the patient who, because of age or other legal disability, is unable to consent of the matters above. I have full right to consent to the matters above, and I consent to same; (b) I hereby indemnify and hold harmless the Facility, its employees, agents, medical staff, partners and affiliates from any cost or liability arising out of my lack of adequate authority to give this consents.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS. DOCUMENT IS TO BE ONLY SIGNED IN THE PRESCENCE OF A SPINEONE EMPLOYEE.

Print Patient Name: _____

Signature of Patient or Guardian: _____ Date: ☐☐/ Time: ___:_____

Witness to Signature: _____ Date: / / Time: ___:_____

Patient Label