

sierra ambulatory surgery center LLC

400b sierra college drive **grass valley, ca** 95945

phone 530.272.3428

fax 530.272.3429

email sierraasc@gmail.com

Patient Forms

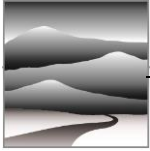
Instructions:

The below forms and notices are in Adobe's Portable Document Format (.PDF)

NONE OF YOUR PERSONAL DATA CAN BE SAVED ON THE PDF FORM.

To use the forms in this packet, you may do the following:

- 1) While this packet is open in your browser window, click on the File menu and choose Save As and designate where you would like the document saved on your computer. You may then open the file, type in your responses and print the entire packet to be brought in with you for your appointment.
- 2) Fill out the form completely while on-line and while the file is open in your browser window. If you click on the "back" button or close the browser window, your data is not saved or submitted to SASC. Once the forms have been completely filled out, choose print from the file menu. Once the forms are printed, close your browser window. You can then bring the forms in with you for your appointment.
- 3) Print the form packet out while open in your browser window and fill out the forms by hand.



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PREOPERATIVE INSTRUCTIONS PAIN MANAGEMENT

1. Your surgery/procedure is scheduled on ____/____/____
2. Your arrival time is _____.
3. You will arrive at **Sierra Ambulatory Surgery Center located at 400 Sierra College Drive, Suite B, Grass Valley, CA 95945.**
4. We have scheduled and expect that you will return home the same day as your surgery/procedure. However, as with any medical or surgical procedure, there are rare occasions that our doctor may decide you should be admitted to the hospital. Should this need arise, we will make the necessary arrangements for your admission to Sierra Nevada Memorial Hospital.
5. You need to have a ride home arranged. We require that your ride remain at the facility until you have been cleared.
6. You should also arrange for a responsible **adult to stay with you** during the first 24 hour after your surgery/procedure.
7. **Do Not Eat** any food after midnight the night before your surgery/procedure.
8. You may drink clear liquids until _____ the day of you surgery/procedure. After that, you are to have nothing by mouth, not even water. **If your arrival time is changed please stop drinking clear liquids 2 hours prior to your new arrival time.**
9. You may take morning medications after the above time with sips of water. Please follow the **MEDICATION FORM instructions** that were provided to you or discussed with you.

Some examples of clear liquids are:

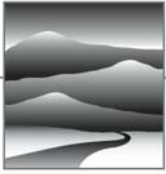
- Black Coffee/Mild Tea (no cream or milk) but sugar is okay
 - Apple/Cranberry Juice
 - Clear broth
 - Jell-O
 - Clear Sports Drink such as Gatorade
 - Mineral, bubbly or plain water
 - Clear soft drinks such as Ginger Ale, Lemon Lime or Club Soda
10. Call Sierra Ambulatory Surgery Center at (530)272-3428 if you develop a cold, sore throat, fever or other illness prior to your surgery/procedure.

AS A PATIENT, YOU HAVE THE RIGHT TO:

- Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy.
- Confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
- Information concerning your diagnosis, treatment, and prognosis, to the degree known.
- The opportunity to participate in decisions involving your healthcare.
- Competent, caring healthcare providers who act as your advocates.
- Know the identity and professional status of individuals providing services.
- Change physicians.
- Adequate education regarding self-care at home written in language you can understand.
- Make decisions about medical care, including the right to accept or refuse medical or surgical treatment.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap, or disability.
- Receive an itemized bill for all services
- File a grievance with the facility by contacting the clinical director at (530) 272-3428.
- Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments.
- Report any complaints to State Representative: California Department Public Health Services (CDPH) 126 Mission Ranch Blvd. Chico, CA 95926; Phone: 530-895-6711; Toll Free 1-800-554-0350 or call Quality Improvement Organization 1-800-MEDICARE(633-4227). Website is www.medicare.gov or www.cms.hhs.gov/center/ombudsman.asp
- Know about any business relationships among the facility, healthcare providers, and others that might influence your care or treatment.

AS A PATIENT, YOU ARE RESPONSIBLE FOR:

- Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate physician(s).
- Following the treatment plan recommended by the primary physician involved in your case.
- Providing an adult to transport you home after surgery and an adult to be responsible for you at home for the first 24 hours after surgery.
- Indicating whether you clearly understand a contemplated course of action and what is expected of you and ask questions when you need further information.
- Your actions if you refuse treatment, leave the facility against the advice of the physician, and/or do not follow the physician's instructions relating to your care.
- Ensuring that the financial obligations of your healthcare are fulfilled as expediently as possible.
- Providing information about and/or copies of any living will, power of attorney, or other directive that you desire us to know about.



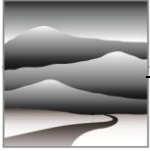
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Financial Disclosure Statement

Dear Patient,

This is to inform you that Sierra Ambulatory Surgery Center LLC is a physician owned business. Dr. John Hagele, Dr. Keith Mercer, Dr. Matthew Zealear and Dr. Gregory Porter have proprietary interests in Sierra Ambulatory Surgery Center LLC. If you have any questions regarding this please feel free to speak to the Medical Director of this facility.



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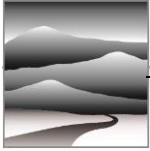
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Cancellation Policy

At Sierra Ambulatory Surgery Center, we attempt to be as courteous to our patients as possible. To meet this goal, it is required that you give at least 24 hours notice prior to canceling or changing your appointment. This will allow us to accommodate other patients that are seeking earlier appointments and to avoid gaps in our surgeon's schedule. Non-emergency cancellations less than 24 hours prior to the surgical procedure will be subject to a \$50.00 cancellation fee that is not covered by insurance. This fee must be paid prior to scheduling any further treatment. We appreciate your cooperation and courtesy to our patients and our facility.



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It Is Each Patient's Responsibility To Know The Benefits & Exclusions Of His Or Her Insurance Policy.

Billing Information

Sierra Ambulatory Surgery Center, LLC maintains a rigorous program of cost containment to assure high-quality health care at a competitive rate. Our charges include the costs associated with the procedure/operating rooms, recovery room, nursing staff, medical-surgical supplies and pharmaceuticals. Our facility fee is billed separately from the fees of the surgeons and anesthesiologists involved in your care; therefore you will receive billing from Sierra View Medical Eye, Inc. for surgeon fees and RC McLean, Inc. for Anesthesiologist and/or Pain Management fees.

Method of Payment

Our Surgery Center, Surgeons & Anesthesiologist are contracted with many health plans. Patients not fully covered by their insurance plans must make financial arrangements prior to the day of the procedure.

We accept Care Credit and all major credit cards, debit cards, or cash as forms of payment.

If you have questions or need assistance please call:

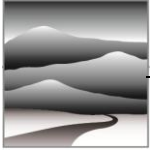
Sierra View Medical Eye Billing Dept. at (530) 272-3411 x204

Sierra Ambulatory Surgery Center Billing Dept. at (530) 272-3428 x220

DO YOU NOW OR HAVE YOU EVER HAD		Y	N	PLEASE LIST OTHER MAJOR ILLNESS / DISEASES	
HEART DISEASE					
CHEST PAIN					
ANKLE SWELLING					
PACEMAKER/IRREGULAR HEARTBEAT					
HIGH BLOOD PRESSURE					
BRONCHITIS / EMPHYSEMA					
ASTHMA / WHEEZING					
HEREDITARY BLEEDING PROBLEMS					
DIABETES					
LIVER DISEASE / JAUNDICE / HEPATITIS					
AIDS / HIV					
DRUG OR ALCOHOL ABUSE					
HIATAL HERNIA / ULCERS / HEARTBURN					
EPILEPSY / CONVULSIONS / SEIZURES					
BACK / NECK PROBLEMS					
STROKE / TIA					
CANCER					
HAVE YOU HAD		Y	N	SURGERIES / HOSPITALIZATIONS	
ANTICOAGULANTS/BLOOD THINNER IN PAST MONTH					
ANY DIET PILLS IN THE LAST MONTH					
CORTISONE / STEROIDS PAST YEAR					
RECENT COUGH OR COLD					
PREVIOUS ANESTHETICS					
BAD REACTION TO ANESTHESIA					
RELATIVES WITH ADVERSE REACTIONS TO ANESTHESIA					
COULD YOU BE PREGNANT?					
LAST MENSTRUAL PERIOD DATE					
ARE YOU AWARE OF THE RISK OF EATING OR DRINKING THE DAY OF ANESTHESIA?					
DO YOU		Y	N		
HAVE ANY PHYSICAL RESTRICTIONS					
HAVE TROUBLE WALKING 1 BLOCK					
HAVE FALSE / CAPPED / LOOSE TEETH					
WEAR CONTACT LENSES, GLASSES, HEARING AIDS, FALSE EYE (CIRCLE)					
DRINK ALCOHOL / SOCIAL DRUG USE AMT _____					
USE TOBACCO NOW? AMT _____					
USE TOBACCO IN PAST YEARS _____					
PRINT NAME:		PATIENT SIGNATURE:		DATE:	
PRINT NAME:		PATIENT SIGNATURE:		DATE:	
PRINT NAME:		PATIENT SIGNATURE:		DATE:	
PRINT NAME:		PATIENT SIGNATURE:		DATE:	
AGE:	HEIGHT:	WEIGHT:	HOME PHONE	CELL/WORK PHONE	OK TO CALL YOU AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO

**SIERRA AMBULATORY SURGERY CENTER
PAIN HEALTH QUESTIONNAIRE**

Patient Label



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Medical Records Release Authorization Form

Practice/Doctors Name _____

Mailing Address _____

Phone Number _____

Fax/E-mail _____

Contact Person _____

Authorization for Release of Identifying Health Information

Patient Name: _____ DOB _____

Patient Phone Number: _____

Patient Address: _____

The professional office names above is authorized to release health information identifying (above patient) under the following terms and condition:

1. Description of the information to be released: _____
2. To whom the information will be released: **Sierra Ambulatory Surgery Center, Inc., LLC**
400B Sierra College Drive, CA 95945 (530)272-3428 Fax (530)272-3429.
3. Purpose of release: _____
4. Expiration date or event: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you do not sign this authorization. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our *Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person listed above.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I have read and understand this form. I am signing it voluntarily; I authorize the disclosure of my health information as described above.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Print Name

Relationship to Patient/Source of Authority

Keith Mercer, M.D.

Matthew Zealear, M.D.

John Hagele, M.D.

Gregory Porter, M.D.