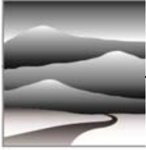


sierra ambulatory surgery center LLC
400b sierra college drive **grass valley, ca** 95945
phone 530.272.3428
fax 530.272.3429
email sierraasc@gmail.com

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.

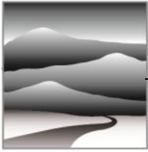
To use the forms in this packet, you may do the following:

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 your 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.

Keith Mercer, M.D. Matthew Zealear, M.D. **John Hagele. M.D.** Gregory Porter, M.D.



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

Acknowledgment of Receipt of Perioperative Information

1. Patient's Rights & Responsibilities/Grievance Information __________

2. Financial Disclosure Statement __________

3. Cancellation Policy __________

4. Patients Financial Responsibility (Patient Confidential File) __________

5. Advanced Directive/Medical Power of Attorney __________

6. Privacy Policy Rights __________

*Please initial above lines

I have received all of the above information in a timely fashion prior to the day of my surgical procedure.

I have read, understand and agree to the above information, instructions and policies and have had all questions pertaining to these topics answered satisfactorily.

______________________________ ______________ ______________
Patient Signature Initials Date

7. Discharge Instructions (To be signed post-operatively)

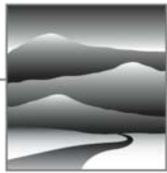
Date of Service	Patient / Caregiver Signature	RN

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.**

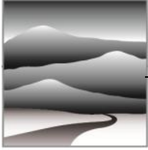


sierra ambulatory surgery center LLC
400b sierra college drive grass valley, ca 95945

Financial Disclosure Statement

Dear Patient,

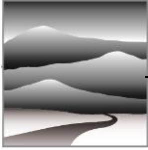
This is to inform you that Sierra Ambulatory Surgery Center LLC is a physician owned business. Dr. John Hagele, Dr. Keith Mercer, Dr. Matthew Zealear and Dr. Gregory Porter have proprietary interests in Sierra Ambulatory Surgery Center LLC. If you have any questions regarding this please feel free to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



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

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.



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

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

GREG PORTER, M.D. **KEITH MERCER, M.D.** **MATTHEW ZEALEAR, M.D.** **JOHN HAGELE, M.D.**

SIERRA AMBULATORY SURGERY CENTER

PATIENT'S CONFIDENTIAL FILE

❑ Dr. ❑Mr. ❑Mrs. ❑Ms.

Patient Name:____
Last First Middle Initial

Date of Birth: _______________________ Age:_________ Sex: M____F ____ Occupation: ____________________________

Home Phone: (___)_____________ Cell Phone: (___)____________ Work Phone: (___)____________

Home/Mailing Address: ____
Street Address City State Zip

Social Security #: ____________-_________-____________ Employer: __________________________________

Spouse's Name: ____ Date of Birth: ____________________

Employer: ____ Phone : _______________________

Referred by Doctor: _________________________________ Family Physician: ___________________________

RACE: Check One
❑ American Indian or Alaskan Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ Other Race
❑ Unknown

ETHNICITY: Check One
❑ Hispanic or Latino
❑ Non-Hispanic or Non-Latino
❑ Unknown

Insurance Information

Primary Insurance Carrier: ____

Name of Insured: ____________________________________ Relationship: _______________________

Secondary Insurance Carrier: ____

Name of Insured: ____________________________________ Relationship: _______________________

Please list a contact person in case of emergency: ___________________________ **Phone:** ____________________

Medicare Lifetime Insurance Authorization

I request that payment of authorized Medicare and Medi-gap benefits be made to me or on my behalf to Sierra ASC, LLC for any services furnished me by that physician group. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for related services.

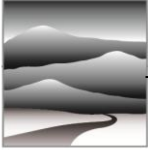
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in line 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I authorized the Release of any Medical Information necessary to process my Insurance claims.

Your signature on this form acknowledges that you agree to full financial responsibility for all services provided if,
1) The services are not covered as a benefit under your Health Insurance plan, or 2) Failure to obtain a referral for services from your primary care physician when required by your Health Insurance Plan.

____ ____________________
Patient Signature Date



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

Advanced Directive / Living Will / Health Care Proxy / Medical Power of Attorney

Because the scope of care at Sierra Ambulatory Surgery Center is limited to elective outpatient surgical procedures, any life-threatening situation that arises will be immediately treated with life-sustaining measures. We do not honor a "Do Not Resuscitate" portion of an Advance Directive.

Please initial one of the statements below that apply to you.

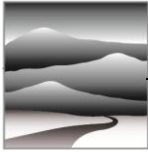
_________ I have an Advance Directive/Living Will/Health Care Proxy/Medical Power of Attorney, but I did not bring it to the Surgery Center. I understand the Surgery Center is requesting a copy of this paperwork and I will provide it as soon as possible.

_________ I have provided Sierra Ambulatory Surgery Center with a copy of my Advance Directive/Living Will/Healthcare Proxy/Medical Power of Attorney.

_________ I do not have an Advance Directive/Living Will/Healthcare Proxy/Medical Power of Attorney. I am aware that this facility will provide me with information about Advance Directives upon my request.

I understand that Sierra Ambulatory Surgery Center does not honor a "Do Not Resuscitate" portion of an Advance Directive, and that life-sustaining measures will be implemented immediately if the need arises. Concurrently, the emergency medical system (EMS) will be activated for emergent patient transfer to Sierra Nevada Memorial Hospital.

Patient Signature:________________________________ Date:______________



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

Receipt of Notice of Privacy Policies & Consent Form

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before using this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment: (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations as described in our ***Notice of Privacy Practices***, but we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Sierra Ambulatory Surgery Center, LLC.

Patient Name: ____

____ ____________________

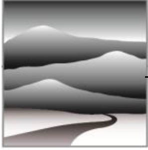
Signature **Date**

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: ____



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

Persons Authorized to Receive Medical Information

I hereby authorize the following person(s) to receive medical information concerning my general medical care and treatment.

Name ______________________________ Relationship: ______________

Home Phone: ______________________ Work/Cell: ______________________

Name ______________________________ Relationship: ______________

Home Phone: ______________________ Work/Cell: ______________________

Name ______________________________ Relationship: ______________

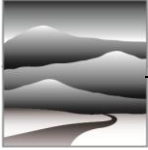
Home Phone: ______________________ Work/Cell: ______________________

Name ______________________________ Relationship: ______________

Home Phone: ______________________ Work/Cell: ______________________

Patient's Name: ____

Signature: ______________________________Date: ________________



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

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