

**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](mailto:sierraasc@gmail.com)

# Patient Forms

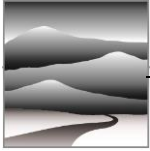
## Instructions:

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.

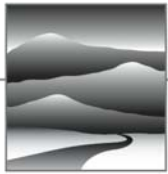


## **AS A PATIENT, YOU HAVE THE RIGHT TO:**

- 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](http://www.medicare.gov) or [www.cms.hhs.gov/center/ombudsman.asp](http://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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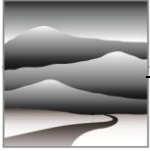
400b sierra college drive **grass valley, ca** 95945

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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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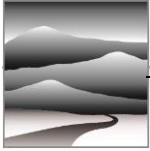
phone 530.272.3428

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email [sierraasc@gmail.com](mailto: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.



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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

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

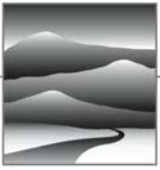
\_\_\_\_\_  
Date



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



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

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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.\*

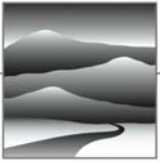
\_\_\_\_\_ I have an Advance Directive/Living Will/Health Care Proxy/Medical Power of Attorney, but I did not bring it to the Surgery Center. I understand the Surgery Center is requesting a copy of this paperwork and I will provide it as soon as possible.

\_\_\_\_\_ 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: \_\_\_\_\_



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## Receipt of Notice of Privacy Policies & Consent Form

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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**

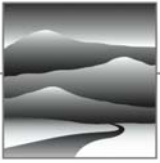
If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

Source of Authority: \_\_\_\_\_

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



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### 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: \_\_\_\_\_

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

## Medical Records Release Authorization Form

Practice/Doctor's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax/E-Mail \_\_\_\_\_

Contact Person \_\_\_\_\_

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### Authorization for Release of Identifying Health Information

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Patient Name: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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

1. Description of the information to be released: \_\_\_\_\_
2. To whom the information will be released: **Sierra Ambulatory Surgery Center 400B Sierra College Dr. Grass Valley, 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 disclose 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: \_\_\_\_\_