DATE

DURANGO
Outpatient Surgery Center
Affiliate of St. Rose Dominican Hospitals

☐ New Patient ☐ Established Pt.

PATIENT INFORMATION

PATIENT NAME (LAST)	(FIRST)	(M.I.)	SSN

HOME PHONE	CELL PHONE	DATE OF BIRTH	AGE	SEX	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

ADDRESS:	APT #	CITY	STATE	ZIP

PATIENT'S EMPLOYER (Responsible Party if patient is a minor or unemployed) ☐ F/T ☐ P/T	DEPT. / EXTENSION	EMPLOYER'S PHONE ( )

EMPLOYER'S ADDRESS	CITY	STATE	ZIP

RESPONSIBLE PARTY INFORMATION

NAME (LAST)	(FIRST)	(M.I.)	SSN:

ADDRESS	CITY	STATE	ZIP

RELATIONSHIP TO PATIENT	HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )

EMERGENCY CONTACT

CONTACT'S NAME	RELATIONSHIP TO PATIENT	PHONE ( )

ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION

1. PRIMARY INSURANCE CO.			PHONE ( )

CLAIM MAILING ADDRESS	CITY	STATE	ZIP

INSURED'S NAME	DATE OF BIRTH	I.D./SS

RELATIONSHIP TO PATIENT	POLICY # or ID#	GROUP # / GROUP NAME	EFFECTIVE DATE

INSURED'S EMPLOYER	EMPLOYERS ADDRESS	☐ F/T ☐ P/T

2. SECONDARY INSURANCE CO.			PHONE ( )

CLAIM MAILING ADDRESS	CITY	STATE	ZIP

INSURED'S NAME	DATE OF BIRTH	I.D./SS

RELATIONSHIP TO PATIENT	POLICY # or ID#	GROUP # / GROUP NAME	EFFECTIVE DATE

INSURED'S EMPLOYER	EMPLOYERS ADDRESS	☐ F/T ☐ P/T

MEDICARE INFORMATION

MEDICARE NUMBER	RETIREMENT DATE	ARE YOU A VETERAN? ☐ Yes ☐ No	DID THE VA REFER TREATMENT? ☐ Yes ☐ No

HAVE YOU SUFFERED FROM BLACK LUNG? ☐ Yes ☐ No	ARE YOU ENTITLED TO MEDICARE SOLELY ON THE BASIS OF END STAGE KIDNEY DISEASE? ☐ Yes ☐ No

INJURY INFORMATION

DATE SYMPTOMS BEGAN:____/____/____	WAS INJURY DUE TO ACCIDENT? ☐ Yes ☐ No	CAR? ☐ Yes ☐ No	WORK RELATED? ☐ Yes ☐ No

DATE OF INJURY:____/____/____	WORKMANS COMP. CARRIER

CLAIM#	ADJ'S NAME	CARRIER PH#

The physician does _____ or does not _____ have an an investment in the Surgery Center. Please contact the physician if you desire further information.

PATIENT SIGNATURE DATE RESPONSIBLE PARTY SIGNATURE DATE REGISTERED BY INITIALS

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FINANCIAL POLICY

1. The patient is responsible for all charges incurred at Durango Outpatient Surgery Center (DOSC). A bill from DOSC for the use of the facility will be sent to the patient and /or the patient's responsible party. The charges on the bill cover the use of pre-op, operating and recovery rooms, medications, supplies, instruments, equipment and the facility staff. These charges do not include any professional physician fees for anesthesia, surgery, pathology, radiology, etc. and any pre-operative testing fees.

2. If you have insurance, DOSC will file a claim for you as a courtesy. If you have not been notified of payment from them my the sixth week following surgery, you should contact your carrier. If you have a deductible, co-pay, or co-insurance due, payment arrangements must be made prior to surgery. Any non-covered amounts, amounts over the usual and customary and compliance penalties will be billed to the patient.

3. DOSC has contracts with many managed care organizations. You are expected to follow the rules of your carrier in obtaining pre-authorizations, referrals, etc. DOSC will assist you with this process if needed and abide by all the rules of these contracts. If DOSC does not have a contract with your carrier, they will attempt to negotiate rates for your procedure with your insurance company/managed care organization but cannot guarantee the result.

4. If you do not have insurance, payment arrangements must be made prior to surgery. If requested, a price quote of charges for your procedure will be given. These quotes are based on averages and may vary significantly from actual charges because every patient's surgery is different. These quotations will not include any physician fees or services.

RELEASE OF INFORMATION

5. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, DOSC may disclose portions of the patient's record, including his/her medical records to any person or corporation which is or may be liable for all or any portion of DOSC charges, including but not limited to insurance companies, health care service plans, workers' compensation carriers, the patient's employer, and utilization review monitoring organizations.

ASSIGNMENT OF BENEFITS

6. I authorize direct payment to DOSC and to the full extent of my authority, I hereby assign to DOSC any insurance benefits otherwise payable to the patient or on the patient or on the patient's behalf for the patient's surgery, treatment or diagnostic procedure(s). It is agreed that payment to DOSC pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that the patient is financially responsible for charges not covered by this assignment.

FINANCIAL AGREEMENT

7. I agree that payment for all charges incurred are the primary responsiblility of the patient or the patient's responsible party. I authorize DOSC or its agent to check with any credit bureau, and to verify the patient's employment or insurance coverage. If the account is sent to any attorney for collection, the patient shall pay, in addition to all sums due, DOSC reasonable attorney's fee and collection expense. If any of my checks are returned by my bank, I understand that I will be charged an additional fee at the prevailing rate at that time.

8. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. I also understand that a photocopy of this release is as valid as the original.

Patient/Parent/Agent _____ Date _____ Time_____

Relationship to Patient_____ Witness_____

DURANGO OUTPATIENT SURGERY CENTER

Patient Informed Consent to Resuscitative Measures

(Not Revocation of Advance Healthcare Directives or Medical Power of Attorney)

All patients have the right to participate in their own healthcare decisions and to make an Advance Healthcare Directive or to execute a Power of Attorney that authorize others to make decisions on their behalf, based upon their expressed wishes, when they are unable to make decisions or unable to communicate decisions.Durango Outpatient Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, Durango Outpatient Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk, but of course, no surgery is without risk.You will discuss the specifics of your procedure with your physician who can answer your questions as to your surgical risks, your expected recovery and care after your surgery.

Therefore, it is our policy (regardless of the content of any Advance Healthcare Directive, instructions from a Healthcare Surrogate or Attorney-in-fact) that if an adverse event occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Healthcare Directive, or Healthcare Power of Attorney.Your signature below does not revoke or invalidate any current Healthcare Directive or Healthcare Power of Attorney.

(If you do not agree with this policy, we are pleased to assist you to re-schedule this procedure.)

(Please check the appropriate box in answer to this question.)

Have you executed an Advance Healthcare Directive,a Living Will or a Power of Attorney that authorizes someone to make Healthcare decisions for you?

Please initial appropriate answer(s):

_____ Yes, I have an Advance Healthcare Directive, Living Will or Healthcare Power of Attorney.

_____ No, I do not have an Advance Healthcare Directive, Living Will or Healthcare Power of Attorney.

_____ I would like to have information on Advance Healthcare Directive.

By signing this document, I acknowledge that I have read and understand the contents and agree to the process described above.

DATE:_____ Signature: _____
(Patient)

If consent to the procedure is provided by anyone other than the patient, the person providing the consent or authorization must sign this form.

DATE:_____Signature:_____
(Patient Advocate)

Print Name:_____

Relationship to Patient:
- ❑ Court appointment guardian
- ❑ Attorney-in-fact
- ❑ Healthcare Surrogate
- ❑ Other:_____

_____
Durango Outpatient Surgery Center Employee

DURANGO
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INFORMED CONSENT TO RESUSCITATIVE MEASURES
DOSC-720 (07-08)

Patient Identification

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home #_____

Work #_____

Mobile #_____

Other _____

E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs.

By providing the information above I agree that DURANGO OUTPATIENT SURGERY CENTER or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, DURANGO OUTPATIENT SURGERY CENTER or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

Mail Communication Preferences

May we send mail to your home address? (If no, please provide an alernate mailing address below.)

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name	Telephone
____ Spouse	_____	_____
____ Caretaker	_____	_____
____ Child	_____	_____
____ Parent	_____	_____
____ Other	_____	_____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been give the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature | Date

_____ _____

Printed Name | Relationship to Patient

Medication Reconciliation Sheet

Patient Stated Home Medications (including herbal and over the counter drugs):

ALLERGIES : _____

_____

Medication	Dosage/Route	Frequency	First Admission Date/Time last taken	Second Admission Date/Time last taken	Third Admission Date/Time last taken	Fourth Admission Date/Time last taken
			reconciled by: _____,RN	reconciled by: _____,RN	reconciled by: _____,RN	reconciled by: _____,RN

_____

Patient Signature

DURANGO
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Pt Sticker

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PRE-ANESTHESIA QUESTIONNAIRE

INSTRUCTIONS: Please indicate by a checkmark (✔) your answer to each question. These answers will greatly help us to give you the best possible care during your procedure. If you do not know an answer please indicate by a question mark (?). If there are multiple answers please circle the appropriate one, be specific, explain if necessary.

AGE _____ SEX _____ HEIGHT _____ WEIGHT _____

MEDICATION ALLERGIES _____ Reaction: _____

ARE YOU ALLERGIC TO LATEX? ❑ Yes ❑ No Reaction: _____

Have you or anyone in your family had an unusual reaction to Anesthesia? ❑ Yes ❑ No Explain: _____

Are you taking any medications, including blood thinners (asprin, ibuprofen, plavix, coumadin, etc.) _____

Please List: _____

Are you taking any herbal medications? ❑ Yes ❑ No

Please List: _____

Have you had or do you still have? When?	Yes	No
1. Are you a diabetic?	❑	❑
2. Do you have a cold?	❑	❑
3. Bronchitis/or chronic cough?	❑	❑
4. Sleep apnea/CPAP Machine	❑	❑
5. Asthma?	❑	❑
6. Emphysema?	❑	❑
7. Shortness of Breath?	❑	❑
8. Any other Lung trouble? If yes, explain: _____	❑	❑
9. Do you smoke? How much _____ day?	❑	❑
10. Rheumatic Fever?	❑	❑
11. Heart Murmur?	❑	❑
12. Any heart valve problem?	❑	❑
13. High Blood Pressure?	❑	❑
14. Do you have a pacemaker? Rate _____	❑	❑
15. Chest Pain/Angina?	❑	❑
16. Heart Attack(s)?	❑	❑
17. Palpitations: Irregular or fast heartbeat?	❑	❑
18. Any Blood Disease? _____	❑	❑
19. Jaundice, Hepatitis, Liver Trouble?	❑	❑
20. Gallbladder trouble?	❑	❑
21. Do you drink alcoholic beverages? How much alcohol/beer in a week? _____	❑	❑
22. Gastric - esophageal problems?	❑	❑
23. Reflux - frequent indigestion? And/or Hiatal Hernia?	❑	❑
24. Seizure disorder?	❑	❑
25. Neurological problems? Stroke, Paralysis, severe head injury?	❑	❑
26. Head or Neck injury or surgery?	❑	❑
27. Back or disc problems or sciatica?	❑	❑
28. Kidney trouble?	❑	❑
29. Thyroid trouble?	❑	❑
30. Any history of street drug use? How long ago? _____	❑	❑

31. Have you had surgery before? Check or list below:

- ❑ Appendectomy
- ❑ Breast/Biopsy
- ❑ Cataracts
- ❑ Gallbladder
- ❑ Hernia
- ❑ Hysterectomy
- ❑ Orthopedic _____
- ❑ Sinus/Nasal
- ❑ Tonsils/Adenoids
- ❑ Other _____

32. Any illness or disease not listed? _____

Please list any information you feel would be helpful in your care:

Date: _____

Signature: _____

Cell Phone Number: _____

PATIENT INFORMATION