

Covenant High Plains Surgery Center

DATE OF SURGERY	PHYSICIAN	MEDICAL RECORD #	DATE OF PRE-OP VISIT
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PATIENT INFORMATION

Patient NAME (LAST, FIRST, MIDDLE)			SOCIAL SECURITY NUMBER		
DATE OF BIRTH	AGE	SEX	RACE	MARITAL STATUS	
MAILING ADDRESS (CITY, STATE AND ZIP)			PHONE NUMBER		
RESIDING ADDRESS (IF DIFFERENT)			CELL PHONE NUMBER		
EMAIL ADDRESS					
EMPLOYER					
EMPLOYER'S ADDRESS (CITY, STATE AND ZIP)			EMPLOYER'S PHONE NUMBER		
GUARANTOR/RESPONSIBLE PARTY		SOCIAL SECURITY NUMBER		RELATIONSHIP	
GUARANTOR/RESPONSIBLE PARTY'S MAILING ADDRESS (CITY, STATE AND ZIP)				PHONE NUMBER	
GUARANTOR/RESPONSIBLE PARTY'S EMPLOYER					
GUARANTOR/RESPONSIBLE PARTY'S EMPLOYER'S ADDRESS (CITY, STATE AND ZIP)			EMPLOYER'S PHONE NUMBER		
PERSON TO CONTACT IN AN EMERGENCY (WHO DOES NOT LIVE WITH YOU)					
ADDRESS (CITY, STATE AND ZIP)			PHONE NUMBER		

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER	POLICY OWNER'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
INSURANCE ID NUMBER	GROUP NUMBER	GROUP NAME	
MAILING ADDRESS (CITY, STATE AND ZIP)			
SECONDARY INSURANCE CARRIER	POLICY OWNER'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
INSURANCE ID NUMBER	GROUP NUMBER	GROUP NAME	
MAILING ADDRESS (CITY, STATE AND ZIP)			

OTHER INFORMATION

IS THIS A WORK-RELATED INJURY? YES NO

If "YES", PLEASE PROVIDE THE INFORMATION BELOW.

DATE OF INJURY	DATE REPORTED TO EMPLOYER	SUPERVISOR'S NAME
EMPLOYER	EMPLOYER ADDRESS	TELEPHONE NUMBER
EMPLOYER'S WORKERS COMPENSATION INSURANCE COMPANY		FILE/CLAIM NUMBER

Pre-Anesthetic Questionnaire

Patient Name: _____

Daytime phone # _____

Procedure _____

DRUG & FOOD ALLERGIES: | | None List (explain reaction):

Latex allergy/sensitivity to tape/band-aids? Circle: Yes No

Ht _____ Wt/BMI _____ (pounds) _____ (kg)

Prior surgeries: _____

Tobacco use? Yes No _____ packs/day x _____ years

Alcohol use? Yes No # drinks per day/week: _____

Caffeine use? Yes No # drinks per day/week: _____

Have pain? Yes No Where: _____ 1-2-3-4-5-6-7-8-9-10

**ANESTHESIA PROBLEMS for you or any blood relative (i.e., delayed awakening, MALIGNANT HYPERTHERMIA, unexplained fever, difficult intubation, vomiting)? Yes No If yes, explain: _____

Which of the following do you have or have you had in the past? Please circle Yes or No to each question.

<p>CARDIAC HISTORY</p> <p>Y N Chest pain Y N Heart attack Y N Heart failure Y N Mitral valve prolapse Y N Rheumatic fever Y N Heart murmur Y N Irregular heartbeats Y N Aneurysms Y N Heart catheterization or stents Y N Heart surgery (e.g. bypass) Y N Pacemaker/Defibrillator Date last checked: _____ Y N Artificial heart valve Y N High blood pressure Y N Cholesterol</p> <p>RESPIRATORY HISTORY</p> <p>Y N Asthma Y N Emphysema or COPD Y N Chronic cough Y N Shortness of breath Y N Sleep APNEA and/or CPAP</p> <p>OTHER MEDICAL HISTORY</p> <p>Y N Blood Clots in legs or lungs Y N Tuberculosis Y N Diabetes: If yes, circle below: Insulin Pills Diet Y N Hypoglycemia Y N Kidney disease If yes, do you have a dialysis shunt or on dialysis? _____</p>	<p>Y N Ulcers Y N Weight loss Y N Thyroid disease Y N Liver disease Y N Hepatitis Circle type if yes: A B C Y N Lupus Y N Anemia Y N Bruise or bleed easily Y N Sickle cell disease Y N Strokes Y N weakness? Y N TIA (mini-stroke) Y N Parkinson's disease Y N Seizures or epilepsy Date of last seizure: _____</p> <p>Y N Migraines Y N Memory loss If yes, do you sign your papers? Y N Y N Psychiatric disorders Y N Depression Y N Glaucoma Y N Artificial joints Y N Artificial limbs Y N Amputee Y N Back pain Y N Neck pain Y N Herniated discs Y N Cancer Type: _____ Chemotherapy Radiation therapy Birth defects: _____</p>	<p>DO YOU:</p> <p>Y N Have anything contagious (fever, cough rash, open sores) Y N Have MRSA, AIDS or HIV Y N Have night sweats Y N Use recreational drugs Y N Get preventative antibiotics before procedures Y N Have you had any recent respiratory infections, other type of infections or hospitalization Describe and list date(s) _____</p> <p>Y N Wear Oxygen Type: _____</p> <p>Y N Wear contact lenses Y N Wear glasses Y N Wear hearing aids Y N Have body piercing (besides ears) If yes, where? _____</p> <p>Y N Have dentures, partials, loose teeth or periodontal disease Y N Use cane, walker or wheelchair Y N Are you prone to falling Y N Have an ostomy</p> <p>Y N Need a translator day of surgery If yes, what language: _____</p>	<p>Y N Take blood thinners or anti-Inflammatories (Plavix, Coumadin, Pradaxa, Effient, Aspirin, Motrin, Advil, Aleve, Mobic, Naprosyn, Celebrex, Aggrenox, etc.)</p> <p>Did you stop this medication? Y N Date last taken: _____</p> <p>WOMEN ONLY:</p> <p>Y N Are you pregnant now Y N Are you breastfeeding now Y N Take hormones or Tamoxifen Y N Ever had a tubal or hysterectomy Last menstrual cycle Date _____</p> <p>_____ Nurse Signature Date</p> <p>_____ _____ _____ _____ _____ _____ _____ _____</p>
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Please list the name(s) of your current physician(s) (i.e. primary care physician, cardiologist, pediatrician, orthopedist):

Physician name	Specialty	Date of visit
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency contact (name/phone number): _____ Responsible Adult: _____

I certify that my health history was reviewed and updated by me on: (sign once per date of service)

Today's Date	Patient Signature	Witness
_____	_____	_____
Today's Date	Patient Signature	Witness
_____	_____	_____
Today's Date	Patient Signature	Witness
_____	_____	_____

IMPORTANT INFORMATION REGARDING THE BILLING
OF YOUR ANESTHESIA SERVICES

The services of your anesthesia care team is provided by North Star Anesthesia Group (NSA) and services are a separately billable from the Covenant High Plains Surgery Center facility fee(s), laborartoy charges or the surgeon’s charges(s). As a convenience, NSA has agreed to file a claim with your insurance company for your anesthesia services. Due to individual coverage variables with each patient’s insurance benefits, NSA may not be able to accurately determine what percentage the insurance carrier will pay for anesthesia services; therefore it is the patient’s responsibility to contact you insurance company for compete benefit information.

North Star Anesthesia Group (NSA) will collect payment for the anesthesia service from the insurance carrier. If there is any remaining balance, NSA will mail the patient a statement. It is the responsibility of the patient to make their payment in full or contact NSA to make payment arrangements.

If you do not have insurance, payment in full is required on or before the day of surgery, unless prior arrangements are made with NSA.

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION
AND CONTRACT FOR PAYMENT

In consideration of services rendered, I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to North Star Anesthesia Group (NSA). This assignment will remain in effect until revoked by me in writing. I hereby authorize NSA to release all information that may be necessary to secure payment for their charges.

I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. Upon receipt of a statement from NSA, I agree to pay the remaining balance in full or contact their office to discuss payment arrangements.

Patient Name

Witness

Signature (Parent or Legal Guardian if patient is a minor)

Date

Please call NSA if you have any questions regarding charges for anesthesia services. Thank you for using Covenant High Plains Surgery Center.

North Star Anesthesia Group
1161 Corporate Drive West, Suite 150
Arlington, TX 76006
(800) 963-3271
or 833-988-4677

Covenant  High Plains Surgery Center

2301 QUAKER AVE, LUBBOCK TX 79410

ADMISSION CONSENT

Additional Blood Testing:

I understand that my physician may order a blood test drawn from me for (including but not limited to) HIV (AIDS) and Hepatitis antibodies. I understand that I can obtain the results of these tests from my physician who can explain them.

_____ I consent to that withdrawal only if an employee or physician has had an accidental exposure to my body fluids. I authorize release of data necessary to process the testing and the insurance claim and I understand there will be no cost to me for this test.

Photographs/Video Tapes:

I understand these photographs and/or video tapes are the property of my surgeon.

_____ I consent for any photographing or video taping deemed necessary by my surgeon for medical scientific or educational purposes provided my identity is not revealed.

I certify that this form has been fully explained to me, that I have read it or have it read to me, and that I understand its contents.

Signature of Patient, Parent, or Legal Guardian

Date

PRINT Name of Patient, Parent, or Guardian

Relationship if signed by person other than Patient _____

WITNESS/INTERPRETER: _____

PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not A Revocation Of Advance Directives Or Medical Powers Of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Center respects and upholds those rights.

However, unlike in an Acute Care Hospital setting, the Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. 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 its risks, your expected recovery and care after your surgery.

Therefore, as a matter of conscience, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care 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 measures already begun will be ordered in accordance with your wishes, Advance Directive or Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

PLEASE CHECK THE APPROPRIATE BOX IN ANSWER TO THESE QUESTIONS.

HAVE YOU EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE, A LIVING WILL, OR A POWER OF ATTORNEY THAT AUTHORIZES SOMEONE TO MAKE HEALTH CARE DECISIONS FOR YOU?

- YES, I HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.
- NO, I DO NOT HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.
- I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES.

If you checked the first box "yes" to the question above, please provide us a copy of that document so that it may be made a part of your medical record.

<p>By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described.</p> <p>By: _____ (Patient's Signature)</p>
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Patient's Last Name:	Patient's First Name:	Date:
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If consent to the procedure is provided by anyone other than the patient, this form must be signed by the person providing the consent or authorization.

<p>I acknowledge that I have read and understand its contents and agree to the policy as described.</p> <p>By: _____ (Signature)</p> <p>_____ (Print Name)</p> <p>Relationship to Patient <input type="checkbox"/> Court Appointed Guardian <input type="checkbox"/> Attorney in Fact <input type="checkbox"/> Health Care Surrogate <input type="checkbox"/> Other</p>
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