Covenant℠ High Plains Surgery Center

Date of Surgery | Physician | Medical Record # | Date of Pre-op Visit

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 ASSESSMENT- PEDIATRIC

Patient Name:_____

Responsible Party_____ Daytime Phone#_____Procedure_____

Wt_____**(lbs)**_____**(kg)** My nickname is_____ **NPO**: Time:_____ Verbalized Understanding ☐

I am allergic to (**drug & food**)_____**Latex allergy /Sensitivity** to tape/band-aids **?** ☐ Yes ☐ No

Medications / Supplement(s) List: Med/Rec Form Completed ☐ **Yes** ☐ **No** Hospitalizations_____

Surgeries I have had _____Are immunizations up to date? ☐ Yes ☐ No

Anesthesia Problems: *Patient~*_____ *Relative~* _____

(i.,e. unexplained fever, MALIGNANT HYPERTHERMIA, nausea/vomiting)

I have pain ☐ **Yes** ☐ **No** Where? _____ If yes, is it Mild (0-3) Moderate (4-7) or Severe (8-10)

Patient lives with: _____ Last name if different: _____

Who will be with patient the day of surgery_____ ****Power of Attorney needed if child will be with someone other than custodial parent**** Other info the doctor should know: _____

PLEASE READ CAREFULLY AND CIRCLE ALL THAT APPLY TO YOUR CHILD

CARDIOVASCULAR	RESPIRATORY	NEUROMUSCULAR	AIRWAY
NO PROBLEM	**NO PROBLEM**	**NO PROBLEM**	**NO PROBLEM**
ANEMIA	ASTHMA	ADD / ADHD SPINAL DEFORMITIES	LOOSE TEETH:
BLEEDING TENDENCIES	ALLERGIES	CEREBRAL PALSY MUSCULAR DYSTROPHY	_____
MURMUR	NASAL CONGESTION	SEIZURE: FREQUENCY:_____	MISSING TEETH:
RHEUMATIC FEVER	RECENT COLD/INFECTIONS	MENTAL OR PHYSICAL DISABILITY OR DELAY	_____
OTHER:	OTHER:	***FAMILY HISTORY OF ABOVE*** ☐ YES ☐ NO	BRACES
		OTHER:	OTHER:

ENDOCRINE	GI / GU	BIRTH	MISCELLANEOUS
NO PROBLEM	**NO PROBLEM**	NORMAL FULL TERM	RASHES
DIABETES: CONTROLLED BY:	KIDNEY DISEASE	PREMATURE:	ANYTHING CONTAGIOUS
DIET MEDICATION INSULIN	URINARY INFECTION	Birth Wt._____	HEARING AIDS
RHEUMATOID ARTHRITIS	STOMACH PROBLEMS		GLASSES/CONTACTS
OTHER:	OTHER:	GROWTH/DEVELOPMENT FOR AGE:	Last Menstrual Cycle: _____
		Within normal limits ☐ YES ☐ NO	OTHER:

Please list the name(s) of your current physician(s) (i.,e. primary care physician, cardiologist, pediatrician):

Physician name	**Specialty**	**Date of visit**

Notes: _____

_____

_____

_____

_____

_____

_____

_____
Signature **Date**

☐ Parent ☐ Guardian ☐ Other

_____
Nurse Signature **Date**

I certify that my health history was reviewed and updated by me on:

Today's Date	**Patient/Parent/Guardian Signature**	**Witness**
Today's Date	**Patient/Parent/Guardian Signature**	**Witness**
Today's Date	**Patient/Parent/Guardian Signature**	**Witness**
Today's Date	**Patient/Parent/Guardian 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 LABEL

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.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described.

By: _____
(Patient's Signature)

Patient's Last Name:	Patient's First Name:	Date:

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.

I acknowledge that I have read and understand its contents and agree to the policy as described.

By: _____
(Signature)

_____
(Print Name)

Relationship to Patient

☐ Court Appointed Guardian ☐ Attorney in Fact ☐ Health Care Surrogate ☐ Other