LeBonheur East Surgery Center LP

"Your Right to Know"

The healthcare facility must inform the patient or the patient's representative or surrogate of the patient's rights and must protect and promote the exercise of these rights, as set forth in this document. If a patient is adjudged incompetent under applicable State laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf. If a State court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

GRIEVANCES

An opportunity for you, your family, or a legally appointed representative to express any concerns about your care, with the assurance that any expressed concerns will not interfere with present or future care. The Surgery Center Administrator will assist you with the review and when possible, the resolution of these concerns:

Solus Management Services - 901-516-1716

LeBonheur East Surgery Center – 901-287-4100

Tennessee Health Department - 615-741-3111

Medicare – www.medicare.gov - 800-633-4227

www.cms.hhs.gov/ombudsman

Accreditation Association of Ambulatory Health Care Inc - 847-853-6060

Patient Rights

- To be treated with respect, consideration, and dignity.
- To be free from any act of abuse, discrimination, harassmentor reprisal.
- To expect reasonable continuity of care.
- To personal privacy.
- To receive care in a safe setting.
- To expect that within the healthcare facility's capacity efforts will be made to honor a patient's request for services.
- To receive complete current information concerning diagnosis, treatment, and prognosis, in terms the patient can reasonably expect to understand from their physician. When it is not medically advisable to give that information to the patient, it should be made available to the appropriate person on their behalf.
- To the name of the physician responsible for coordinating their care.
- To receive all information necessary to give informed consent prior to the start of any procedure and/or treatment from their physician.
- To be given the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences.
- To be informed of any relationship of the healthcare organization to other pertinent healthcare and education institutions.
- To know what rules and regulations apply to their conduct as a patient.
- To voice concerns or grievances regarding treatment or care furnished within this facility.
- To receive information concerning policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.
- To be advised if the healthcare facility proposes to engage in or perform human experimental care or treatment, and have the opportunity to accept or decline.
- To the credentials of health care professionals.
- To the disclosures and records that are kept confidential, and to be given the opportunity to approve or refuse their release except when release is authorized by law.
- To expect communication, records, discussion, consultation, examination and treatment to be treated confidentially.
- To examine and receive an explanation of their bill regardless method of payment.
- To change providers if other qualified providers are available

Patient Responsibilities

- Pre-operatively all mentally competent patients 18 years or older (or an emancipated minor) will be asked before their procedure if he/she has an Advanced Directive.
- It is the patient's responsibility to provide a copy of his/her Advance Directive for the Surgery Center and the admitting physician.
- The Advanced Directive will be provided to the receiving hospital, if the patient is transferred to the hospital.
- Patients not having an Advanced Directive will be given the information upon their request. The information is available in the Patient Information Book, kept in the surgery center lobby.
- Should the patient be designated a Do Not Resuscitate (DNR), the patient will be directed to discuss with his/her Surgeon the appropriateness of implementation of a DNR in the Surgery Center setting.
- If the patient insists on implementing a DNR while at the Surgery Center, the procedure will be canceled and re-scheduled in a hospital setting.
- The Surgery Center will make available the State of Tennessee approved forms for use, should an Advanced Directive be desired.

Do you have an Advanced Directive? ☐Yes ☐No
If yes, did you bring them with you? ☐Yes ☐No ☐N/A

I have received verbal and written communication of "Right to Know" prior to the start of the surgical procedure.

Patient / Surrogate Signature Date

NOTIFICATION OF PRIVACY PRACTICES AND FINANCIAL POLICY

Complete and Sign the Following

This shall serve as notice that a copy of the "Notice of Privacy Practices" and the Financial Policy has been made available to me. You may also request a copy of these documents from the front desk associates.

Patient/Guardian Signature Date

I agree to have the Surgery Center staff acknowledge my presence here at the Center and my general condition to family and friends who inquire about me either in person or by telephone.

☐ **I agree** ☐ **I disagree**

I acknowledge that a responsible adult must remain at the Surgery Center until I or my child is discharged.

☐ **I agree**

I give permission to allow the Surgery Center to give or receive information regarding my post-operative care to the following people:

Phone	Person/Relationship	May Leave a Message
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

NOTE: If there is anyone that you wish for us to **withhold information**, please list below:

Person	Person

☐ I have no one that you will need withhold my information from.

Patient/Guardian Signature Date

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE, BENEFITS, AND FINANCIAL AGREEMENT

This Surgery Center shall be referred to as the provider in this document.

A. MEDICAL AND SURGICAL CONSENT: The undersigned consents to any examination (x-ray or otherwise), including but not limited to, laboratory procedures, medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedure or treatment (including the placement of prosthesis within a patient's body), radiation therapy (x-ray, cobalt, radium or other), photograph and/or other services rendered the patient by members of the medical staff, their representatives and/or associates, and provider's employees under the instructions of the physician, podiatrist or dentist. The undersigned also consents to observation or surgical, diagnostic, or other procedures by medical personnel in training or by other appropriate persons permitted by provider or departmental policy. To protect against possible transmission of blood-borne diseases such as Hepatitis-B or Acquired Immune Deficiency Syndrome (AIDS), I understand that it may be necessary to test the patient's blood while in the Surgery Center. If, for example, a Surgery Center employee or physician is stuck by a needle while drawing blood or sustains a scalpel injury, I understand and consent that the patient's blood will be tested. I further understand that the blood will not be routinely tested for these diseases and the results of any testing will be kept confidential in accordance with Tennessee Law.

B. HEALTH CARE PROVIDERS: Medical personnel, including treating physicians, should provide my care or treatments, may not be employees of the provider. These persons include emergency room physicians, pathologists, radiologists, anesthesiologists, anesthetists, psychologists and certain nurses and aides, I agree that it is my responsibility to ask questions sufficient to make informed decisions based on the employment status/affiliations of my health care providers.

C. TISSUE SPECIMEN ANALYSIS AND DISPOSAL: Should my medical stay involve the removal of any tissue or parts of my body, including fetus or afterbirth, they may be retained or disposed of by the provider or forwarded to appropriate diagnostic entities for review and/or analysis.

D. MEDICAL INFORMATION RECEIVED: The patient, if in a condition to receive it, and if not, the undersigned representative of the patient, acknowledges that he/she has been informed concerning the need for medical services, the purpose of the patient entering the facility, and the planned examinations, procedures, and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained.

E. RELEASE OF INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: The provider or my physician, may disclose all or any part of the record of the patient to any person or organization which is or may be liable for or responsible for payment of any of the charges of the provider but not limited to insurance companies, medical or hospital service companies, worker's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or intermediaries or carriers any information needed for this or a related Medicare/TennCare claim. I hereby authorize direct payment to the above-named provider of all health, hospitalization, and all other insurance benefits and assign and transfer all benefits that I am entitled to or otherwise: are due or payable to me or my estate from any source. I have completed and signed the Medicare Secondary Payor Questionnaire.

F. FINANCIAL AGREEMENT: The undersigned SEVERALLY, agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned in accordance with the regular rates and terms of the provider, as set forth in the providers procedure index, and is payable to the provider. While any insurance or other protection related to the account of the provider may be hereby assigned to and payable directly to the provider, the undersigned clearly understands that the obligation to pay the provider is primarily on the patient and the undersigned, and while insurance received by the provider will be applied to the patient's account, any part of the account not paid by insurance is nevertheless owing and payable. In case of default of payment, and if these accounts should be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees (which shall equal one-third of any balance due), cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest are waived. It is further agreed that due to the high cost of billing and refunding small amounts, the surgery center will not bill or refund under payments or overpayments of less than five dollars ($5.00) on final balances, except on a request of the patient or responsible party.

The above conditions apply to all units within the provider system and this form is valid at each provider for the length of the admission including any discharge and readmission to another unit or facility of provider during hospitalization. The release of information set forth hereinabove is valid for one year from the date of discharge, and the assignment of insurance benefits and financial agreement is valid and binding until final settlement of the account is received. Futher, I agree that the terms of this agreement shall apply to all subsequent and future services rendered to me, my spouse, or my dependents by the provider unless this agreement is revoked by written notice sent certified mail prior to the subsequent date of admission.

If you have any comments or concerns about any part of your care, please call 901-516-1716.

THE UNDERSIGNED CERITIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ THE FOREGOING, HAS RECEIVED A COPY HEREOF, IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND THE FOREGOING CONDITIONS OF ADMISSION ARE FULLY UNDERSTOOD AND ACCEPTED.

Signature: _____ Date: _____ SMS.1.121.1109

Date Completed

ANESTHESIA INFORMATION

During surgery, your child will probably receive general anesthesia. The medical history of your child or other family members may influence our choice of anesthetics. Your thorough responses to these questions will help the anesthesiologist evaluate such factors. We ask for you to bring your child in prior to surgery to speak to an anesthesia person. If you have further questions, or would like to have your child examined, please call 901-287-4100.

Procedure		
Surgeon/Dentist		Date of Surgery
Patient's full name		Date of Birth
Parent's name		Email -
Home phone	Work phone	Cell phone

PLEASE ANSWER THE FOLLOWING QUESTIONS

Yes	No	Concern		
		Did your child have any problems when he/she was born or require a longer than normal hospitalization?		
		If yes, explain:		
		Was your child born early?	If so, Birth weight	Weeks
		Has your child had any other surgeries or anesthesia?		
		If yes, list:		
		Has your child had any other hospitalizations?		
		If so, list and state the reason:		
		Has your child or any family member have or ever had any problem with anesthesia or any muscle disease?		
		If yes, explain:		
Answer the following questions about your child's history:				
		Heart problems (murmurs, irregular heart beats, high blood pressure)		
		Breathing problems (asthma, pneumonia, snoring, sleep apnea)		
		Liver problems (jaundice, hepatitis)		
		Kidney problems (infection, failure)		
		Neurological problems (seizures, cerebral palsy, retardation)		
		Blood disorders (bleeding problems, anemia, sickle cell disease)		
		Frequent vomiting		
		Endocrine problems (diabetes, thyroid)		
		Has your child ever been on an apnea monitor?		
		Has your child ever had unexplained fevers?		
		Does your child have any current infection (runny nose, cough, congestion)?		
		Does your child have any loose teeth?		
Patient Rights Questions		□ Yes □ No	Does your child have an Advance Directive?	
		□ Yes □ No	Is your child an organ donor? (State-required information needed)	

Completed by: ☐ Parent/Surrogate ☐ SC Associate ☐ Anesthesia

Signature

Patient Home Medication List – Medication Reconciliation

Provided by the Patient/Surrogate
(Include prescriptions, over the counter, herbals, vitamins and birth control pills/patch)

Allergies		
	☐ NKAS (No Known Allergies or Sensitivities)	☐ **Allergies & their reactions**
		☐Latex/Rubber ☐ Adhesive ☐Environmental ☐Food (specify above)

Medications	Medication(s)	Dose	Route	Date of last dose		
				1st Visit	2nd Visit	3rd Visit
			☐ PO ☐ Patch ☐ Injection ☐ Other ____________			
			☐ PO ☐ Patch ☐ Injection ☐ Other ____________			
			☐ PO ☐ Patch ☐ Injection ☐ Other ____________			
			☐ PO ☐ Patch ☐ Injection ☐ Other ____________			
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			☐ PO ☐ Patch ☐ Injection ☐ Other ____________			
			☐ PO ☐ Patch ☐ Injection ☐ Other ____________			

Review the Allergies and Medications for the patient – Healthcare Provider Signature

Date	Preop -	OR -	PACU -
Date	Preop -	OR -	PACU -
Date	Preop -	OR -	PACU -

LEBONHEUR EAST SURGERY CENTER
CONSENT FOR SURGERY/PROCEDURE

Patient Label

I authorize Dr._____and the associates/assistants, residents or other physicians in training, of his/her choice to perform the following surgery/and or procedure:

_____

_____

_____

and such additional therapeutic surgery/special procedure as his/her judgment may indicate on the basis of findings during the course of said surgery/procedure.

SURGEON'S ATTESTATION: Prior to the procedure, I discussed the condition requiring treatment and the nature, purpose, risks, and benefits of the operation(s), surgery/procedure(s), possible alternative methods of treatment, including non-treatment, and the possibility of complications with my patient or the patient's authorized representatives. I provided my patient or his/her representative with the opportunity to ask questions and answered all questions to their apparent satisfaction. I have reviewed the surgical consent form and verified that the planned surgery/procedure as well as surgical/procedure site is accurate. **Surgeon's initials:**_____

Dr._____has fully explained and discussed with me:

- the nature and purpose of the surgery/special procedure
- the possibility that complications may arise or develop
- the significant risks which may be involved
- possible alternate methods of treatment
- the prognosis if no treatment is received
- no warranty or guarantee has been made as to the result of care received
- advance directives (including Do Not Resuscitate orders) are suspended during the surgery/special procedure and immediate post-operative/special procedure periods
- The Surgeon will be present for all the critical parts of the surgery and/or procedure. The Surgeon may be out of the operating room for some or all of the surgical tasks done by the associate assistants, residents or physicians in training if the Surgeon decides it is safe to do so.
- The physician was present during the use of any interpretive services to obtain informed consent
  ☐ Yes ☐ N/A

I authorize and direct the above named physician or dentist and his/her associates/assistants to provide and/or arrange for provisions of such additional services as they deem reasonable and necessary, including, but not limited to the performance of services including pathology and radiology and the transfusion of blood/blood products. Any tissues, blood specimens, or other parts surgically removed may be retained and disposed by the Surgery Center in accordance with its accustomed practice.

I authorize and direct the above named physician or dentist to administer sedation/anesthesia or to arrange for the administration of sedation/anesthesia by a member of the Anesthesiology Department.

I also consent to the observation and/or participation in the surgery by medical personnel in training or by other appropriate persons permitted by my physician or dentist and authorize the Surgery Center, to take films or photographs that my physician or dentist may make or request.

I hereby state:

- I have read and understand the Consent Form
- All my questions about the surgery and/or procedure have been answered in a satisfactory manner
- All blank spaced above were filled in or deleted prior to my signature
- My signature indicated that I have given consent

_____ _____

Signature of patient, parent, / guardian Date and time

_____ _____

Relationship of person signing for patient Signature /Title of witness

Time out was conducted after drape and before incision/injection. All team members agreed. Circulator initial _____