DATE OF SURGERY	DOCTOR:	ACCOUNT #

Parkway Surgery Center

A Joint Venture with Dr. Steve Donaldson and United Surgical Partners

PATIENT INFORMATION

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

DATE OF BIRTH	AGE	SEX	MARITAL STATUS
			☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

HOME PHONE	CELL PHONE	EMAIL ADDRESS

ADDRESS:	APT. #	CITY	STATE	ZIP

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

EMPLOYER'S ADDRESS	CITY	STATE	ZIP

RESPONSIBLE PARTY INFORMATION

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

ADDRESS	APT. #	CITY	STATE	ZIP

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

EMERGENCY CONTACT

CONTACT'S NAME	RELATIONSHIP TO PATIENT	PHONE ( )

INSURANCE INFORMATION

1. PRIMARY INSURANCE CO.	PHONE ( )

CLAIM MAILING ADDRESS	CITY	STATE	ZIP

INSURED'S NAME		DATE OF BIRTH	SS

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

INSURED'S EMPLOYER	EMPLOYERS ADDRESS

2. SECONDARY INSURANCE CO.	PHONE ( )

CLAIM MAILING ADDRESS	CITY	STATE	ZIP

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

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

INSURED'S EMPLOYER	EMPLOYERS ADDRESS

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 BASED ON A DISABILITY? ☐ Yes ☐ No	ARE YOU ENTITLED TO MEDICARE DISABILITY 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

Parkway Surgery Center

A Joint Venture Between
St. Rose Dominican Hospital and United Surgical Partners

FINANCIAL POLICY

1. The patient is responsible for all charges incurred at Parkway Surgery Center (PSC). A bill from PSC 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, PSC will file a claim for you as a courtesy. If you have not been notified of payment from them by 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. PSC has contracts with many managed care organizations. You are expected to follow the rules of your carrier in obtaining pre-authorizations, referrals, etc. PSC will assist you with this process if needed and abide by all the rules of these contracts. If PSC 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, PSC 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 PSC's 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 PSC and to the full extent of my authority, I hereby assign to PSC any insurance benefits otherwise payable to the patient or on the patient's behalf for the patient's surgery, treatment or diagnostic procedure(s). It is agreed that payment to PSC, 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 responsibility of the patient or the patient's responsible party. I authorize PSC 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 an attorney for collection, the patient shall pay, in addition to all sums due PSC, reasonable attorney's fees 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 _____

PARKWAY 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 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. Parkway Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, Parkway Surgery 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 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 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 or withdrawal of treatment measures already begun will be ordered in accordance with your wishes. Advance Healthcare Directive, or Health Care Power of Attorney. Your signature below does not revoke or invalidate any current Health Care Directive or Health Care 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 Health Care Directive, a Living Will or a Power of Attorney that authorizes someone to make Health Care decisions for you?

Please initial appropriate answer(s):

____ Yes, I have an Advance Healthcare Directive, Living will or Health Care Power of Attorney.

____ No, I do not have and Advance Healthcare Directive, Living Will or Health Care 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 policy 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
- ☐ Health Care Surrogate
- ☐ Other:_____

_____
Parkway Surgery Center Employee

Parkway Surgery Center

A Joint Venture with St. Rose Dominican and United Surgical Partners

INFORMED CONSENT TO RESUSCITATIVE MEASURES

PSC-720 (1-5-03)

Patient Identification

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

Place Patient Identification Label Here

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 Parkway 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, Parkway 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 alternate 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 given 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

Parkway Surgery Center

A Joint Venture with St. Rose Dominican and United Surgical Partners

Pt Sticker

PSC 762 (04-10)

Parkway
PSC
Surgery Center
A Joint Venture with St. Rose Dominican and United Surgical Partners

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. Asthma?	❑	❑
5. Emphysema?	❑	❑
6. Shortness of Breath?	❑	❑
7. Any other Lung trouble?	❑	❑
If yes, explain: _____		
8. Do you smoke? How much _____ day?	❑	❑
9. Rheumatic Fever?	❑	❑
10. Heart Murmur?	❑	❑
11. Any heart valve problem?	❑	❑
12. High Blood Pressure?	❑	❑
13. Do you have a pacemaker? Rate _____	❑	❑
14. Chest Pain/Angina?	❑	❑
15. Heart Attack(s)?	❑	❑
16. Palpitations: Irregular or fast heartbeat?	❑	❑
17. Any Blood Disease? _____	❑	❑
18. Jaundice, Hepatitis, Liver Trouble?	❑	❑
19. Gallbladder trouble?	❑	❑
20. Do you drink alcoholic beverages?	❑	❑
How much alcohol/beer in a week? _____		
21. Gastric - esophageal problems?	❑	❑
22. Reflux - frequent indigestion?	❑	❑
And/or Hiatal Hernia?	❑	❑
23. Seizure disorder?	❑	❑
24. Neurological problems?	❑	❑
Stroke, Paralysis, severe head injury?	❑	❑
25. Head or Neck injury or surgery?	❑	❑
26. Back or disc problems or sciatica?	❑	❑
27. Kidney trouble?	❑	❑
28. Thyroid trouble?	❑	❑
29. Any history of street drug use?	❑	❑
How long ago? _____		

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

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

_____

_____

31. Any illness or disease not listed? _____

_____

_____

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

_____

_____

_____

_____

Date: _____

Signature: _____

Print: _____

Cell Phone Number: _____

PATIENT INFORMATION