sierra ambulatory surgery center LLC
400b sierra college drive **grass valley, ca** 95945

Welcome to Sierra Ambulatory Surgery Center!

We have designed our Center to provide you with the highest quality surgical care in a warm and caring environment. Your doctor is supported by a highly skilled team of registered nurses and other healthcare professionals. By using state of the art techniques, equipment and medications, we expect that you will recover quickly from your procedure and anesthesia, allowing you to return to the comfort of your home within a couple of hours after your arrival to Sierra Ambulatory Surgery Center. Our office staff is committed to making your visit with us as pleasant and comfortable as possible. The following information will be helpful in preparing for your surgery. If you have any questions, please contact us at 272-3428. We look forward to the privilege of serving you.

Sincerely,

Your Sierra Ambulatory Surgery Center Team

GREG PORTER, M.D. **KEITH MERCER, M.D.** **MATTHEW ZEALEAR, M.D.** **JOHN HAGELE, M.D.**

SIERRA AMBULATORY SURGERY CENTER

PATIENT'S CONFIDENTIAL FILE

❑ Dr. ❑Mr. ❑Mrs. ❑Ms.

Patient Name:_____
Last First Middle Initial

Date of Birth: _____ Age:_____ Sex: M____F ____ Occupation: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Home/Mailing Address: _____
Street Address City State Zip

Social Security #: _____-_____-_____ Employer: _____

Spouse's Name: _____ Date of Birth: _____

Employer: _____ Phone : _____

Referred by Doctor: _____ Family Physician: _____

RACE: Check One
- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Other Race
- ❑ Unknown

ETHNICITY: Check One
- ❑ Hispanic or Latino
- ❑ Non-Hispanic or Non-Latino
- ❑ Unknown

Insurance Information

Primary Insurance Carrier: _____

Name of Insured: _____ Relationship: _____

Secondary Insurance Carrier: _____

Name of Insured: _____ Relationship: _____

Please list a contact person in case of emergency: _____ Phone: _____

Medicare Lifetime Insurance Authorization

I request that payment of authorized Medicare and Medi-gap benefits be made to me or on my behalf to Sierra ASC, LLC for any services furnished me by that physician group. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in line 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I authorized the Release of any Medical Information necessary to process my Insurance claims.

Your signature on this form acknowledges that you agree to full financial responsibility for all services provided if, 1) The services are not covered as a benefit under your Health Insurance plan, or 2) Failure to obtain a referral for services from your primary care physician when required by your Health Insurance Plan.

_____ _____
Patient Signature Date

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email sierraasc@gmail.com

Advanced Directive / Living Will / Health Care Proxy / Medical Power of Attorney

Because the scope of care at Sierra Ambulatory Surgery Center is limited to elective outpatient surgical procedures, any life-threatening situation that arises will be immediately treated with life-sustaining measures.

Please initial one of the statements below that apply to you.

_____ I have an Advance Directive/Living Will/Health Care Proxy/Medical Power of Attorney, but I did not bring it to the Surgery Center. I understand the Surgery Center is requesting a copy of this paperwork and I will provide it as soon as possible.

_____ I have provided Sierra Ambulatory Surgery Center with a copy of my Advance Directive/Living Will/Healthcare Proxy/Medical Power of Attorney.

_____ I do not have an Advance Directive/Living Will/Healthcare Proxy/Medical Power of Attorney. I am aware that this facility will provide me with information about Advance Directives upon my request.

I understand that in the event of a life-threatening emergency, life-sustaining measures will be implemented immediately. Concurrently, the emergency medical system (EMS) will be activated for emergent patient transfer to Sierra Nevada Memorial Hospital along with a copy of my Advanced Directive to consider in my evaluation and treatment.

Patient Signature:_____ Date:_____

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Receipt of Notice of Privacy Policies & Consent Form

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before using this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment: (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations as described in our ***Notice of Privacy Practices***, but we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Sierra Ambulatory Surgery Center, LLC.

Patient Name: _____

_____ _____
Signature **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Print Name Relationship to Patient

Source of Authority: _____

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Medical Records Release Authorization Form

Practice/Doctors Name _____

Mailing Address_____

Phone Number _____

Fax/E-mail _____

Contact Person _____

Authorization for Release of Identifying Health Information

Patient Name: _____DOB_____

Patient Phone Number: _____

Patient Address: _____

The professional office names above is authorized to release health information identifying (above patient) under the following terms and condition:

1. Description of the information to be released: _____
   _____
2. To whom the information will be released: ***Sierra Ambulatory Surgery Center, Inc., LLC***
   400B Sierra College Drive, CA 95945 (530)272-3428 Fax (530)272-3429.
3. Purpose of release: _____
4. Expiration date or event: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you do not sign this authorization. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our *Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person listed above.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I have read and understand this form. I am signing it voluntarily; I authorize the disclosure of my health information as described above.

_____ _____
Signature **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Print Name Relationship to Patient/Source of Authority

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Persons Authorized to Receive Medical Information

I hereby authorize the following person(s) to receive medical information concerning my general medical care and treatment.

Name _____ Relationship: _____

Home Phone: _____ Work/Cell: _____

Name _____ Relationship: _____

Home Phone: _____ Work/Cell: _____

Name _____ Relationship: _____

Home Phone: _____ Work/Cell: _____

Name _____ Relationship: _____

Home Phone: _____ Work/Cell: _____

Patient's Name: _____

Signature: _____Date: _____

AS A PATIENT, YOU HAVE THE RIGHT TO:

1. Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
2. Competent, caring healthcare providers who act as your advocates.
3. Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap, or disability.
4. Be Free from any act of discrimination or reprisal.
5. Receive care in a safe setting.
6. Be free from all forms of abuse or harassment.
7. Personal and informational privacy.
8. Confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
9. Information concerning your diagnosis, treatment, and prognosis, to the degree known. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
10. 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.
11. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State Law may exercise the patient's rights to the extent allowed by State Law.
12. Know the identity and professional status of individuals providing service.
13. Change providers if other qualified providers are available.
14. The opportunity to participate in decisions involving your healthcare.
15. Make decisions about medical care, including the right to accept or refuse medical or surgical treatment.
16. Be fully informed about the treatment or procedure and the expected outcome before it is performed.
17. Adequate education regarding self-care at home written in language you can understand.
18. Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments.
19. Voice grievances regarding treatment of care that is, or fails to be, provided.
20. File a grievance with the facility by contacting the Medical Director, Dr. Porter at (530) 272-3428.

21. Report any complaints to State Representative: California Department Public Health Services (CDPH) 126 Mission Ranch Blvd. Chico, CA 95926; Phone: 530-895-6711; Toll Free 1-800-554-0350, Quality Improvement Organization 1-800-MEDICARE (633-4227); Website is www.medicare.gov or www.cms.hhs.gov/center/ombudsman.asp , or call AAAHC at 847-853-6060; Website is info@AAAHC.org

22. Receive an itemized bill for all services.

23. Know about any business relationships among the facility, healthcare providers, and others that might influence your care or treatment.

AS A PATIENT, YOU ARE RESPONSIBLE FOR:

1. Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate physician(s).

2. Providing a complete list of prescription and non-prescription medications and any allergies or sensitivities.

3. Following the treatment plan recommended by the primary physician involved in your case.

4. Providing an adult to transport you home after surgery and an adult to be responsible for you at home for the first 24 hours after surgery.

5. Indicating whether you clearly understand a contemplated course of action and what is expected of you and ask questions when you need further information.

6. Your actions if you refuse treatment, leave the facility against the advice of the physician, and/or do not follow the physician's instructions relating to your care.

7. Ensuring that the financial obligations of your healthcare are fulfilled as expediently as possible.

8. Providing information about and/or copies of any living will, power of attorney, or other directive that you desire us to know about.

9. Being respectful of all healthcare providers and staff as well as other patient.

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Financial Disclosure Statement

Dear Patient,

This is to inform you that Sierra Ambulatory Surgery Center LLC is a physician owned business. Dr. John Hagele, Dr. Keith Mercer, Dr. Matthew Zealear and Dr. Gregory Porter have proprietary interests in Sierra Ambulatory Surgery Center LLC. If you have any questions regarding this please feel free to speak to the Medical Director of this facility.

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FINANCIAL POLICY

Thank you for choosing Sierra Ambulatory Surgery Center (SASC) as your out-patient surgery provider. We are committed to providing you with quality and affordable health care. The following is summary of our Financial Policies.

PAYMENT POLICY:
Payment of co-pays and deductibles are required either prior to surgery and/or after surgery if calculated or discovered after surgery. This includes applicable deductibles, co-insurances, and co-payments for participating insurance companies. Self-pay patients who do not have insurance will pay prior to services being rendered. SASC accepts cash, personal checks, money orders, debit cards, as well as all credit cards. There is a $25 service charge for returned checks.

INSURANCE:
Patients are responsible to know the benefits and exclusions of his/her insurance policy.
We bill participating insurance companies as a courtesy to you; however, you are responsible for all charges. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us so we can make the appropriate changes and help you receive your maximum benefits. Please contact your insurance company with any questions you may have regarding your coverage.

OUTSTANDING BALANCE/NONPAYMENT:
Patients with an outstanding balance of 90 days overdue must make arrangement for payment prior to scheduling future procedures. If your account is 90 days overdue, you will receive a letter stating you have 30 days to pay your account in full. Partial payment will not be accepted unless otherwise arranged. Please be aware that if a balance remains unpaid, we may refer your account to an outside collection agency. Subsequently, you and your family may be discharged from SASC.

CANCELLATION POLICY/MISSED APPOINTMENTS:
At Sierra Ambulatory Surgery Center, we attempt to be as courteous to our patients as possible. To meet this goal, it is required that you give at least 24-hour notice prior to cancelling or changing your appointment. This will allow us to accommodate other patients that are seeking earlier appointments and to avoid gaps in our surgeon's schedule. Non-emergency cancellations less than 24 hours prior to the surgical procedure will be subject to a $50 cancellation fee that is not covered by insurance. This fee must be paid prior to scheduling any further treatment. We appreciate your cooperation and courtesy to our patients and our facility.

BILLING INFORMATION:
Our charges include costs associated with the procedure/operating rooms, recovery room, nursing staff, medical-surgical supplies and pharmaceuticals. Our facility fee is billed separately from the fees of the surgeons and anesthesiologist involved in your care; therefore, you may receive billing from the following:
Sierra Ambulatory Surgery Center (Facility fee)
Sierra View Medical Eye (Ophthalmologist Professional fee)
RC McLean (Anesthesiologist and/or Pain Management fees)

If you have questions or need assistance, please call:
Sierra Ambulatory Surgery Center Billing Dept.: (530) 272-3428 x 212
Sierra View Medical Eye Billing Dept.: (530) 272-3411 x 204
RC Mclean Billing Dept.: (714) 347-1000

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Acknowledgment of Receipt of Perioperative Information

1. Patient's Rights & Responsibilities/Grievance Information _____

2. Financial Disclosure Statement _____

3. Cancellation Policy (Financial Policy) _____

4. Patients Financial Responsibility (Financial Policy) _____

5. Advanced Directive/Medical Power of Attorney _____

6. Privacy Policy Rights _____

*Please initial above lines

I have received all of the above information in a timely fashion prior to the day of my surgical procedure.

I have read, understand and agree to the above information, instructions and policies and have had all questions pertaining to these topics answered satisfactorily.

_____ _____ _____
Patient Signature Initials Date

7. Discharge Instructions (To be signed post-operatively)

Date of Service	Patient / Caregiver Signature	RN

Your Safety During Outpatient Treatment at Sierra Ambulatory Surgery Center

While you are receiving care at Sierra Ambulatory Surgery Center, many of the processes our staff follow to keep you safe are unseen. However, we want you to know about some of the measures we take so that you can be assured that safety is a constant part of your care.

- **Expect our Staff to:**
  - Sanitize their hands when they enter and leave your care.
  - Introduce themselves when they first meet you and wear ID badges.
  - Confirm your identity before medications are given or procedures are performed.
  - Check the information on your ID band.

- **Our specially trained surgeons and staff protect your safety by following strict surgery preparation processes.**
  - The surgery team pauses their surgery preparation activities as a group to remove distractions while they confirm that you and your procedure are matched correctly.
  - They have you participate in marking the site of your surgery to verify that the correct surgery is performed.
  - They decrease the risk of surgical infections by thoroughly disinfecting their hands and forearms prior to surgery, and by checking that all instruments are properly sterilized and working properly.
  - They select the safest type of anesthesia for you.
  - They account for all surgical equipment before the procedure is finished.
  - They teach you how to care for your surgical site.

- **Keep Communication Channels Working:**
  - If you are given an identification armband, wear it throughout your stay.
  - Treatment areas have call bells. Press the button to notify staff that you need help.

- **Speak Up:**

  Tell Us About Any Changes in the Way You Feel:
  - New or unrelieved pain
  - New, different or worsening symptoms
  - Changes in abilities, strength or response to treatments

- **Please talk to our staff if you:**
  - See any unsafe situation or think something is not right
  - Don't have full understanding
  - Have information about yourself that you want us to know
  - Think staff has confused you with another patient
  - Have questions or concerns. You can speak to:
    - ◊ Staff who are taking care of you
    - ◊ Medical Director of Sierra Ambulatory Surgery Center
  - Ask questions; seek extra information – it's your right to know what is happening to you!
    - ◊ Write down facts your doctor and nurses tell you before you leave Sierra Ambulatory Surgery Center.
    - ◊ Read medical forms before you sign them.

Your Safety During Outpatient Treatment at Sierra Ambulatory Surgery Center

- **Tell Us About:**
  - Allergies that you have to food, medications, latex and other items
  - Medications, herbs and supplements that you have been taking recently
  - Any special diet, cultural or religious practices or concerns you have
  - Any medical conditions or surgeries that you have had
  - Any limitations or disabilities that may affect your safety such as difficulty walking, balance or vision issues
  - Anyone that you would like to restrict from visiting

- **Follow Infection Prevention Practices:**
  - **For Hand Hygiene:**
    - ◊ Wash hands or use hand sanitizer before eating, after using the bathroom, after sneezing or coughing and regularly during the day.

  - **For Respiratory Hygiene:**
    - ◊ Cover your cough! Use tissues when coughing or sneezing or cough into your elbow.

  - **Quit Smoking**
    - ◊ People who smoke get more infections.

Sierra Ambulatory Surgery Center
Anesthesia Information Sheet

You have been scheduled for surgery at Sierra Ambulatory Surgery Center. An anesthesiologist, a physician with special training in the techniques and methods of anesthesia, will provide care for you before, during, and immediately after your surgery.

There are several types of anesthesia, one or more of which may be suitable for your surgical procedure and medical condition. Your anesthesiologist will discuss with you the various anesthetic options and risks specific to your anesthetic care and medical condition. While modern anesthesia is generally very safe, there are always risks involved with any medical or surgical procedure. Your anesthesiologist is trained to recognize potential problems and provide treatment early if the need should arise. You should be aware that complications may occur in spite of the best medical care, and, rarely, may not respond fully to treatment. With any anesthetic, the risks may range from very minor to serious bodily harm, or even death. It should be kept in mind, however, that serious complications arising from the administration of anesthesia are quite rare.

The following is a brief description of the type of anesthesia that will be utilized for your procedure. You are encouraged to ask your anesthesiologist all questions that you may have regarding anesthesia and how it may relate to your surgery or medical condition. You should feel free to also communicate to your anesthesiologist your feelings and concerns about your planned anesthetic. With all modes of anesthesia, of course, you are continuously and carefully monitored throughout your surgery.

MONITORED ANESTHESIA CARE (MAC) or INTRAVENOUS CONSCIOUS SEDATION:

Pain relief for some surgeries may be accomplished using local anesthesia to anesthetize the surgery site where the surgery will be performed. Your anesthesiologist or nurse will monitor you carefully and may give intravenous medicines to relieve anxiety and produce drowsiness, if desired. Complications with this type of anesthesia are quite rare. These can include an allergic or adverse reactions to the anesthetic or to one of the medicines utilized, seizure, or even death.