Reproductive Specialty
Surgical Center, Inc.
15500 Sand Canyon Ave, Ste 110
Irvine, Ca. 92618

PATIENT

LAST NAME:______________ FIRST NAME:______________ MI:____ MARITAL STATUS: M S OTHER

ADDRESS:______________ CITY:__________ ST:_____ ZIP:__________

BEST Ph # TO REACH YOU: __________ H / W / C (circle one) OK TO LEAVE A MESSAGE YES NO (circle one)

2ND BEST Ph # TO REACH YOU: __________ H / W / C (circle one) OK TO LEAVE A MESSAGE YES NO (circle one)

D.O.B:__________ AGE:_____ DRIVER'S LIC #:__________ ST:_____ S.S.N:__________ E-MAIL__________

OCCUPATION: __________ WORK HRS: __________ EMPLOYER:__________

EMP ADDRESS:______________ CITY:__________ ST:_____ ZIP:__________

PARTNER

LAST NAME:______________ FIRST NAME:______________ MI:____

ADDRESS (if different):______________ CITY:__________ ST:_____ ZIP:__________

BEST Ph # TO REACH YOU: __________ H / W / C (circle one) OK TO LEAVE A MESSAGE YES NO (circle one)

2ND BEST Ph # TO REACH YOU: __________ H / W / C (circle one) OK TO LEAVE A MESSAGE YES NO (circle one)

D.O.B:__________ AGE:_____ DRIVER'S LIC #:__________ ST:_____ S.S.N:__________ E-MAIL__________

OCCUPATION: __________ WORK HRS: __________ EMPLOYER:__________

EMP ADDRESS:______________ CITY:__________ ST:_____ ZIP:__________

Referral information

WHOM MAY WE THANK FOR THIS REFERRAL? ***Name of Ob/Gyn:*** __________

___Physician (Name)__________ ____Internet _____ Support Group _____Attended Seminar

___Friend (Name)__________(Address) __________ Is this our Patient? Y N

___Newspaper (Which one)__________ Other (Please Specify) __________

Insurance information (Insurance Info for BOTH parties MUST be given)

PATIENT

PRIMARY INS:______________ INSURED'S NAME:__________ HMO PPO POS EPO OTHER

IF HMO, WHICH MEDICAL GROUP ARE YOU ASSIGNED TO? __________ ID#:__________ GRP #:__________

CLAIMS ADDR: ______________ CTY:__________ ST:_____ Zip:__________ PH #: __________

PARTNER

PRIMARY INS:______________ INSURED'S NAME:__________ HMO PPO POS EPO OTHER

IF HMO, WHICH MEDICAL GROUP ARE YOU ASSIGNED TO? __________ ID#:__________ GRP #:__________

CLAIMS ADDR: ______________ CTY:__________ ST:_____ Zip:__________ PH #: __________

______________ ______________ ______________
Emergency contact person (not living with you) Relationship Phone

I HAVE READ AND AGREE TO THE FINANCIAL POLICIES ENCLOSED

______________ / __________ ______________ / __________
Patient's signature Date Partner's signature Date

______________ ______________
e-mail e-mail

******** PLEASE PROVIDE COPIES OF BOTH SIDES OF YOUR AND YOUR PARTNER'S INSURANCE CARDS ********

NP.inf.form-REV 2-07

Reproductive Specialty Surgical Center, Inc.
15500 Sand Canyon Suite 110
Irvine, CA 92618

PATIENT RECONCILIATION MEDICATION LIST
Home Medication list is as provided by Patient
(Including precriptions, over the counter, herbals, vitamins and birth control pills or patch.)
ALLERGIES: ____
____
____

I take only IVF medications: ☐ Yes ☐ No

Medication Name	Last Dose	Date/Time

After surgery continue all medication unless otherwise indicated. Contact Physician with any questions.

FACILITY USE ONLY

☐ Steroid injection given in operating room
Allergy/Medication list reviewed and verified with: ☐ Patient ☐ Other___________ on day of service as current and complete:______________________________ (Nurse signature)

ADDITIONAL HOME MEDICATIONS FOR PATIENT DISCHARGE

Medication Name		Dose/Route/Freguency/Comments			Last Dose	Rx Given?

Aditional Information: ____
____

☐ Reviewed with patient ______________________________(Nurse Signature)
☐ A copy of this form was provided to the patient upon discharge.

Surgical Center, Inc.
15500 Sand Canyon Suite 110
Irvine, CA 92618

ANESTHESIOLOGY HEALTH HISTORY

Arrival Time: ____________

Your responses to this questionnaire provide part of the information needed by your anesthesiologist to select the most suitable type of anesthesia for you and your particular situation. Please answer all the questions.

INFORMATION:

Name: ______________________ Male ☐ Female ☐

Date of Surgery: __________ Telephone: __________

Weight: __________ Height: __________

First day of last menstrual period: __________ Could you be pregnant? ______ Are you breast feeding? ______

Name of personal doctor other than your surgeon: ______________________

SPECIAL INSTRUCTIONS:

1. **DO NOT EAT OR DRINK** anything **(including water)** for 8 hours prior to surgery unless otherwise ordered by your physician.
2. If you are taking diabetic medication, omit it on the day of surgery unless otherwise ordered by your physician.
3. Take your regular medicine for high blood pressure, heart problems or seizure problems etc. on the day of surgery with a sip of water unless otherwise ordered by your physician.
4. Omit "water pills" on the day of surgery unless otherwise ordered by your physician.

QUESTIONS:

Operation that is planned: ______________________

____

____

Previous Surgeries/Operations: ______________________

____

____

Are you in good health? Yes No

If no, what medical problems do you have now or have you had in the past?

Please list: ______________________

____

____

Have you ever been hospitalized? Yes No

Hospital: ______________ Date: ______________

Reason: ______________________

____

Do you take medications, drugs, pills, herbal supplements or vitamins? Yes No

Please list: ______________________

Why do you take these medications? ______________________

____

Do you have any allergies to medications or latex? Yes No

Please list: ______________________

____

(Rev:slb 2/08)

(continued on back)

When was the last time you had anything to eat or drink? ____________________

HEALTH INFORMATION

	Question	Circle YES or NO		Comments
1.	Have you ever had a problem with anesthesia or surgery?	YES	NO	________
2.	Has any blood relative had a problem with anesthesia?	YES	NO	________
3.	Do you or have you ever smoked? # of packs/day? ____ Stopped ____	YES	NO	________
4.	Do you have a cough or cold?	YES	NO	________
5.	Have you ever had asthma or sleep apnea?	YES	NO	________
6.	Have you had bronchitis, pneumonia or abnormal chest X-ray?	YES	NO	________
7.	Do you get short of breath walking up two flights of stairs?	YES	NO	________
8.	Have you had any difficulty breathing?	YES	NO	________
9.	Have you ever had high blood pressure?	YES	NO	________
10.	Do you have discomfort or pain in your chest or angina?	YES	NO	________
11.	Have you ever had a heart attack or congestive heart failure?	YES	NO	________
12.	Have you ever had an irregular heart beat?	YES	NO	________
13.	Have you ever had an abnormal electrocardiogram (ECG)?	YES	NO	________
14.	Have you ever had a heart murmur?	YES	NO	________
15.	Do you drink alcohol? How much? ________	YES	NO	________
16.	Have you ever had yellow jaundice or hepatitis?	YES	NO	________
17.	Have you had any recent exposure to contagious diseases?	YES	NO	________
18.	Have you ever given yourself intravenous drugs?	YES	NO	________
19.	Have you had possible exposure to AIDS?	YES	NO	________
20.	Have you ever had a stroke?	YES	NO	________
21.	Do you have numbness or weakness in an arm or leg?	YES	NO	________
22.	Have you ever had epilepsy, seizures or black-out spells?	YES	NO	________
23.	Do you have frequent headaches?	YES	NO	________
24.	Do you have back problems?	YES	NO	________
25.	Have you ever had kidney disease?	YES	NO	________
26.	Do you have diabetes?	YES	NO	________
27.	Do you have a goiter or thyroid disease?	YES	NO	________
28.	Do you have arthritis?	YES	NO	________
29.	Do you have problems opening your mouth/moving your neck?	YES	NO	________
30.	Have you ever had broken bones of the face, neck or back?	YES	NO	________
31.	Have you ever had glaucoma or other eye problems?	YES	NO	________
32.	Have you had an ulcer, hiatal hernia, heartburn or GERD?	YES	NO	________
33.	Do you have loose teeth, dentures or caps on your teeth?	YES	NO	________
34.	Do you have any bleeding tendencies?	YES	NO	________
35.	Do you have any unusual muscle problems or disease?	YES	NO	________
36.	Any other health problems? ____________	YES	NO	________

List subjects (numbers) you wish to discuss with the Anesthesiologist: ____________________

To the best of my knowledge, the above information is accurate and my questions have been answered. **Initials:** ______

Your anesthesiologist is a physician whose anesthesiology training currently includes at least four years of college, four years of medical school, a year of internship and three years of residency (a period of special training in anesthesiology). Your anesthesiologist is responsible for providing your anesthesia and preserving your life functions during the surgical procedure.

You can expect to be billed separately for the services of your anesthesiologist.

Signature ____________________

Reproductive Specialty Surgical Center, Inc.
15500 Sand Canyon Ave, Ste 110
Irvine, Ca. 92618

INFORMED CONSENT FOR ANESTHESIA

Modern anesthesia carries risk minimal enough that virtually everyone can be offered its benefits. However every type of pain relief (anesthesia) has certain risks, which are known by your doctors. In most cases these risks are minimal. California law requires informed consent. The type of anesthetic drug or technique will be chosen after discussion amongst you, your surgeon and your anesthesiologist.

Types of Anesthesia

- GENERAL ANESTHESIA (The most common type of anesthesia for surgery). There are several methods of giving general anesthesia. Many anesthetic drugs are now available and they help make your anesthesia safer than ever before. The selection of which drugs are used depends on your physical condition and the type of surgery you are having. Usually general anesthesia is administered by injecting medicines into the vein or having you breathe a gas from the anesthesia machine.
- REGIONAL ANESTHESIA (Used to numb only a specific part of the body). A local anesthetic (numbing medicine) is injected into the area near major nerves where it blocks pain sensations. There are many types of regional anesthesia. The most common are: Spinal and epidural blocks. Spinal and epidural anesthesia involve injecting an anesthetic into or near the spinal fluid, effectively numbing nerves that serve the lower part of your body. They're often used for pelvic and lower extremety surgeries.
- MONITORED ANESTHESIA (Use of local anesthetic-numbing medicine or sedation). Your surgeon will use a local anesthetic (numbing medicine) in the area of your surgery. An anesthesiologist will provide continuous monitoring to assure your safety and may give you medicines to help you rest comfortably while your surgeon works. Typically, monitored anesthesia is an option for surgeries in areas that can be numbed by local anesthetics.

In spite of good medical care, anesthesia may cause serious bodily harm, heart attack, coma and even death in a very small percentage of cases. The following are **examples** of risks. **This is not an all-inclusive list.**

1. **BREATHING PROBLEMS:** To assist your breathing, tubes may be put in your windpipe or trachea which may cause injury to your vocal cords, windpipe, nose, teeth, tongue or lips. The vocal cords may go into spasm which could result in death. Chocking or aspiration of fluid and/or stomach contents may occur. During or after your surgery, you may develop a collapsed lung or pneumonia.

2. **REACTIONS TO INTRAVENOUS DRUGS, BLOOD, SOLUTIONS AND ANESTHESIA GASES:** Anesthetic drugs may stop your heart or breathing or cause harm to your kidneys, liver and other vital organs. Almost all patients having surgery require an I.V. (intravenous). This may result in infection, blood clot formation, nerve injury, and allergic reaction to tape or plastic needles.

3. **REACTIONS TO LOCAL ANESTHETICS OR INJECTABLE DRUGS:** Injections may cause infection abscesses, nerve damage, convulsions and shock.

4. **PRESSURE DAMAGE/BURNS:** Your position on the operating table may cause pressure damage leading to pain, numbness or paralysis. The equipment used to record your bodily functions and to control bleeding may cause burns and even electrocution.

All of the above risks are uncommon but may occur with little warning or cause. This information is not given in order to produce anxiety but is to comply with California State Law.

Do you wish to discuss aesthesia risks with the anesthesiologist? YES/NO (circle one)

I am aware that there may be serious risks with EVERY anesthetic including death. I have read, understand, been advised and warned about the risks. I give my consent for the provision of anesthesia.

Signature of patient/parent/guardian ___________________________ Date__________

Reviewed by Anesthesiologist ________________________________ Date_________

Name/Signature of Interpreter ________________________________ Date _________

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California.
(800) 633-2322 www.mbc.ca.gov

____

Diplomate, American Board of Anesthesiology

PATIENT NOTIFICATION

Disclosure of Ownership

□ Physician does have financial interest in this facility
□ Physician does not have financial interest in this facility.

PATIENT RIGHTS:

- The patient has the right to be informed of his/her rights in advance of receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, economic, education, religious background or the source of payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to change providers if other qualified providers are available.
- Be advised if the physician has a financial interest in the surgery center.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand. Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Be informed of the facility's policy and state regulations regarding advance directives and be provided advance directive forms if requested.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his/her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before medical records can be made available to anyone not directly concerned with their care. Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and , as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing, cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record within a reasonable time frame.
- Be advised of the facility's grievance process, should he/she wish to communicate a concern regarding the quality of the care they received. Notification of the grievance process includes: whom to contact to file the grievance, and that he/she will be provided with a written notice of the grievance determination that contains the name of the facility's contact person, the results of the grievance and the grievance completion date.
- Be advised of contact information for the state agency to which complaints can be reported, as well as contact information for the Office of the Medicare Beneficiary Ombudsman.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting their care of treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate thereof of the continuing healthcare requirement following his/her discharge from the facility.
- Examine and receive an explanation of his/her bill regardless of source of payment.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

PATIENT RESPONSIBILITIES:

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over-the-counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.
- The patient is responsible for his/her actions should you refuse treatment or not follow your physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible to inform the facility about the patient's advance directives.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

ADVANCE DIRECTIVE NOTIFICATION

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power 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. The Surgery Center of Irvine respects and upholds those rights.

However, unlike in an acute care hospital setting, the Surgery Center of Irvine 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 recover, and care after surgery.

Therefore, 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 treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official state forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

PATIENT COMPLAINT OR GRIEVANCE

- If you have a problem or complaint, please speak to the receptionist or your caregiver. We will address your concern(s) promptly.
- If necessary, your problem or complaint will be advanced to the Administrator and/or Quality Assurance coordinator for resolution.
- If you are not satisfied with the response of the Surgery Center, you may contact:

  Department of Health Services
  Division of Health Facilities
  2150 Towne Centre Place
  Anaheim, CA 92806
  (714) 456-0630
  Or
  AAAHC
  5250 Old Orchard Rd, Ste 200
  Skokie, IL 60077
  (847) 853-6060
- All Medicare beneficiaries may file a complaint or grievance with the Medicare Beneficiary Ombudsman. You may call: 1-800-MEDICARE and they will direct your inquiry to the Medicare Ombudsman. You may write them at:

  Center for Medicare and Medicaid Services
  7600 Security Boulevard
  Baltimore, MD 21244

You may visit the Ombudsman's webpage on the web at: www.cms.hhs.gov/center/ombudsman

I received information on patient right's & responsibilities, Physician ownership disclosure, advance directive policy and the grievance policy at least one day advance of my surgery.

____

Patient/Patient Representative Signature

____

Date

PATIENT LABEL

Assignment of Benefits, Facility Fees

________The undersigned authorizes, whether signing as patient or as patient's agent, direct payment to this provider, Reproductive Specialty Surgery Center any benefits otherwise payable to or on behalf of the undersigned for this treatment/services if rendered. In the absences of such payment, provider is further assigned all necessary rights to enforce collection of such benefits or payments. It is agreed that payment to the provider, by any company, pursuant to this authorization, shall discharge said company only to the extent of such payment. It is understood that the patient is financially responsible for charges not collected by this agreement. The patient authorizes the provider to contact the employer and/or company responsible for the payment of any benefits for the purposes of determining the existence and extent of benefits, and authorizes the release of any and all information in the possession of the employer and/or company necessary to determine the existence and/or extent of such benefits.

For and in consideration of services rendered, the patient agrees that this provider shall have an irrevocable lien, equal to the charges for the services rendered, on any recovery due that patient because of the injury or the illness that required this provider's services, whether the recovery is by judgment, settlement, arbitration, civil procedure, award, hearing award, compensation, or insurance payment. This assignment of benefits includes any and all benefits payable directly to insured. If payment is sent to the insured, the insurer shall continue to be held liable by the provider as payment has not been received by the provider, and arbitration or civil procedure will be filed by the provider against the insurer. The provider is hereby appointed as my representative for all appeals, arbitration, civil procedure and request for consideration.

Acknowledgement of Financial Responsibility

________I hereby authorize my Insurance Company to pay by check make payable and mailed directly to: **Reproductive Specialty Surgery Center, 15500 Sand Canyon Drive Suite 110, Irvine, CA 92618**, for the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, the **Reproductive Specialty Surgery Center** will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in current manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient surgery center in the collection of the outstanding fees.

________Furthermore, I hereby acknowledge that any payment send directly to me by my insurance company for medical services rendered by the **Reproductive Specialty Surgery Center** is for reimbursement of the surgery center for provision of medical services. I hereby agree that such payment will be endorsed by me and/or the insured and/or the responsible party if the patient is a minor, and sent to **the Reproductive Specialty Surgery Center** immediately and directly.

________The Surgery Center fees apply only to **Reproductive Specialty Surgery Center** and do not include all fees generated by the procedure, including but not limited to, fees due by the Surgeon, Anesthesiologist, Pathologist and Reference Laboratory. Fees not included shall be billed separately.

Designation of Authorized Representative for Claims

I hereby authorize the facility administrator and the **Reproductive Specialty Surgery Center** to be my representative and to act on my behalf to pursue collection of any claims for services rendered on my behalf, and to appeal any adverse benefit determinations under my insurance benefit plan, if any. I also authorize them to receive, on my behalf, from any companies responsible for payment of claims, any and all notices, documents, correspondence and other items relevant to claims for services rendered on my behalf.
I have reviewed and acknowledge the above charges and statement regarding fees.

Providers Representative Signature ______________________________ Date____________

Patient/Patient Representative Signature ______________________________ Date____________

Reproductive Specialty Surgery Center
15500 Sand Canyon Drive Suite 110
Irvine, CA 92618

PATIENT LABEL