FRONT RANGE
SURGERY CENTER

Authorization to Release Information

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to individuals you must sign this form. Signing this form will only give consent to release this information to the following individuals indicated below. This consent form will not allow Front Range Orthopedic Surgery Center to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow Front Range Orthopedic Surgery Center to release my medical and/or billing information to the following individual(s):

1._____Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Patient Printed Name:_____

Patient Signature:_____Date_____

Authorization to Leave Messages with Household Members, Answering Machine, or Personal Voicemail

Occasionally it is necessary for the staff of Front Range Orthopedic Surgery Center to leave messages for patients. The purpose of these messages is to obtain information regarding a scheduled procedure. At no time will a representative of Front Range Orthopedic Surgery Center discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient
Name:_____

Patient Signature:_____Date_____

FRONT RANGE SURGERY CENTER

Summary Notices of Privacy Practices

Dear Front Range Orthopedic Surgery Center Patient,

This Privacy Notice is being provided to you as a *requirement of a federal law*, the Health Insurance Portability and Accountability Act (HIPAA). It is the policy of Front Range Orthopedic Surgery Center to comply with the federal regulations regarding HIPAA. We strongly believe in protecting the confidentiality and security of your health information.

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** The notice is provided in two sections. This page briefly summarizes how we handle your health information, and the section found in your packet provides further details of our privacy policies and procedures.
2. **How we may use and disclose your health information**. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign and authorization to disclose information, you can later revoke it to stop any future uses and disclosures.
3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.
4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change to our policies, we will change our notice and post the new notice in our waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.
5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, please contact Vicky Burrack at 720-494-3200. You may also send a written complaint to the U.S. Department of Health and Human Services. FROSC can provide you with the appropriate address upon request. You may also file a complaint with our accrediting association, AAAHC at 847-853-6060 or Report Medicare Fraud & Abuse at 800-HHS-TIPS (1-800-447-8477).

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received both sections of this Notice of Privacy Practices. Then return this acknowledgement of receipt to the receptionist.

Signature:_____

Printed Name:_____ Date:_____

FRONT RANGE SURGERY CENTER

Patient Identification

PRE-OPERATIVE & PRE-ANESTHETIC ASSESSMENT

HAVE YOU HAD OR STILL HAVE	YES	NO
A cold, presently		
Sleep apnea		
Use of home oxygen		
Emphysema		
Asthma		
Other lung disease, e.g. TB		
Do you or have you smoked?		
Packs per day?		XXX
Heart attack, When?		
Chest pain, angina		
Irregular or skipped beats		
Heart murmur		
High blood pressure		
Heart failure		
Heart catheterization		
Angioplasty, bypass surgery		
Circulation problems		
History of blood clots		
Anemia or sickle cell disease		
Jaundice, hepatitis		
Liver disease		
Alcoholic beverages, daily		
Thyroid problems		
Kidney or bladder disorder		
Diabetes		
Gastric reflux/GERD		
Hiatal hernia		
Colon problems		
Arthritis		
Back or disc problems		
Migraine headaches		
Seizures / epilepsy		
Stroke / paralysis		
Numbness or tingling		
Other neurologic problems		
Frequent black-out episodes		
Ever addicted to drugs?		
Recreational use of drugs?		
Diagnosed with cancer		
Could you be pregnant?		
Last menstrual period		
Do you get motion sick		
History of nausea or vomiting		
with pain medicines		
after surgery		

Pediatric patients. Premature			
Peds. Immunizations up to date			
HAVE YOU HAD OR STILL HAVE	**YES**	**NO**	
Chest x-ray in last year			
EKG in last 6 months			
Lab work in last 2 weeks			
Partials or dentures			
Capped or loose teeth			
Body jewelry			
Anesthesia problems yourself or family			
Do you have an Advanced Directive?			
Latex sensitivity / Allergy			

Other illness:

Previous Surgeries: **When?**

Current Medications Including Herbal, Over the Counter, Supplements:
See List of Medications

Allergies to Medications: **Type of Reaction:**

Do not fill in any information below - Doctor use only

Signature of Patient **Date**

Age: _____ M / F NPO: _____

Mental Status: Normal___ Altered___

Airway: I II III IV

Lungs:

Heart:

ASA: I II III IV

Plan: GA MAC GA/MAC Regional:_____

Post-Op Pain Mgmt. Block: Supraclavicular ISB AXB FEM Adductor canal Popliteal

Anesthesia management & risks explained to patient/guardian.
Consent to proceed. ❑

Surgery site verified by patient: L R BIL NA

EKG:

H/H:_____ FBS:_____ K+:_____

Comments:

Anesthesiologist Signature Date

FRONT RANGE
SURGERY CENTER

1610 Dry Creek Drive, Suite 100, Longmont CO 80503
(720)494-3200 Fax (720)494-3209

PATIENT RIGHTS & RESPONSIBILITIES

As a patient of Front Range Orthopedic Surgery Center you have the following rights and responsibilities:

- The *right* to receive quality care and safe treatment given in a respectful and considerate manner.
- The *right* to receive care that is free of abuse, harassment or acts of discrimination or reprisal.
- The *right* to privacy regarding your medical care in case discussion, consultation, examination and treatment.
- The *responsibility* to be considerate of other patients and staff and to respect their rights to privacy and property.
- The *right* to receive all information necessary from your physician to give informed consent prior to the start of any procedure and/or treatment and the *responsibility* to ask questions if you do not understand any aspect of your care and treatment.
- The *right* to participate with your physician in making decisions involving your health care and the *right* to choose a surrogate decision maker in the event one is needed.
- The *right* to know the names, professional status and experience of the personnel providing care and the *responsibility* to be considerate and respectful of those who are caring for you.
- The *right* to know whether the facility is involved in any teaching, research or experimental programs.
- The *right* to refuse any drugs, tests, procedures or treatments, and to be informed of the medical consequences of your decision.
- The *right* to be informed of the surgery center's rules and regulations as they pertain to your admission.
- The *right* to receive an estimate of the charges for services based on your admitting diagnosis, and an estimate of any co-payments or other charges that may not be covered by your carrier, based on the insurance information you have provided.
- The *right* to view your medical record within the guidelines established by law (Only those individuals who are involved in your care or are authorized by law have access to your medical record. Anyone else wishing to view your medical record must obtain written consent from you).
- The *right* to change physicians if other qualified physicians are available.
- The *responsibility* to provide accurate, honest and complete information about your medical history that will help us care for you, including information about medications and drugs include over-the counter products, recreational drug use and dietary supplements, and any allergies or sensitivities you have used, previous illnesses, injuries or medical care you have received, and information about your current health status.
- The *responsibility* to follow your health care provider's instructions, take medications as prescribed and ask questions concerning your health care, if necessary, once you have agreed to the recommended care.
- The *right* to express complaints and concerns about your care without fear of recrimination.
- The rights to have a representative/surrogate file a grievance, formal or informal, written or verbal complaint on the patient's behalf. These can be regarding abuse, neglect or ASC compliance issues.

Formal grievances can be filed by contacting the Clinical Director at (720) 494-3201 or completing a grievance form which can be obtained from the receptionist.

You may also file a complaint with our accrediting association, AAAHC at 847-853-6060 or the Colorado Department of Health and Environment: by email to: hfdintake@cdphe.state.co.us, In the "Subject Line", enter: *ASC* Complaint Intake; by phone @ 303-692-2827 or 1-800-886-7689, ext. 2827, by fax @ 303-753-6214 or by mail to CDPHE, HFEMSD-A2, Attention: *ASC* Complaint Intake, 4300 Cherry Creek Drive South, Denver, CO 80246-1530. Medicare beneficiaries may contact the Medicare beneficiary Ombudsman @ http://www.medicare.gov/ombudsman/resources.asp.

PHYSICIAN OWNED FACILITY

I understand that the physicians on staff at Front Range Orthopedic Surgery Center providing medical services are in fact the owners of the facility.

ADVANCED DIRECTIVES

I consent to all resuscitative measures as deemed necessary by my physicians in the event of a life threatening emergency. Front Range Orthopedic Surgery Center feels that patients are in reasonably good health and of low surgical risk making resuscitation appropriate for conditions of preserving life, until transfer to a hospital occurs. I consent to emergency transfer to another facility (Longmont United Hospital or Exempla) in case of the need for emergency hospital care. The admitting facility is not affiliated or in partnership with Front Range Orthopedic Surgery Center.

Do you have an Advance Directive: ___Yes ___No

If you have any questions regarding any information here please call (720) 494-3200.
I have reviewed and understand the Patient Bill of Rights.

_____ _____

Signature of Patient or Responsible Party Date Time

FRONT RANGE SURGERY CENTER

List of Medications

Patient Name _____ Date_____ Time_____
Pharmacy Name _____Pharmacy Phone Number or Address _____
Allergies _____
Please list all medication you are currently taking, *<u>including any medications you are holding because of surgery, over the counter medications and herbal remedies.</u>*

Medications	Dosage	Last Taken	Directions/Frequency	Reason for taking	Ordering Physician

_____ _____
Patient signature **Date**

Below For Post Operative

Medications you received at FROSC today (Circled if given): Pepcid(Famotidine), Versed(Midazolam), Fentanyl, Ancef, Cleocin(Clindamycin), Zofran(Ondansetron), Propofol, Toradol, Dexamethisone, Phenergan(Promethazine), Dilaudid, Others:_____. ESI patients: Omnipaque, DepoMedrol, Lidocaine, Xylocaine MPF.

Resume all home medications as previously taken with the following additions or exceptions:
☐ Check box if no additions or exceptions.
Begin taking Aspirin 81mg or 325mg, 1 or 2 times a day starting _____ and continuing for _____ days.
You may use non-steroidal anti-inflammatories (NSAID) such as Ibuprofen (Motrin,Advil) or Aleve (Naproxen) as needed. Your surgeons recommends: Ibuprofen 400mg every 4hours or 600mg every 6hours or 800mg every 8hours. Aleve (Naproxen) 1 tablets every 12hours as needed.
_____ If checked, do not take NSAIDS for more than 5 days post-op as they may inhibit bone growth.

New prescriptions given today

Medications	Dosage	Directions/Frequency	Reason for taking	Ordering Physician

If you receive a prescription for a "controlled" (Schedule 11 through V) drug, your identifying prescription information will be entered into Colorado's Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you. Your prescription information in the database is a protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

_____ _____
Signature of RN obtaining original list Physician signature Date/Time

_____ _____
Signature of discharge RN Signature of patient or caregiver on DOS Date/Time

Note to patient: Please take this medication list to your next doctor's appointment. It is recommended that you bring a list of your current medications to each medical appointment.