ASSOCIATES SURGERY CENTER

JAMES LOWE, MD
PLASTIC SURGERY

WHITNEY TYLER, RN
NURSE DIRECTOR

Dear Cosmetic Surgical Center Patient,

We would like to take this opportunity to thank you for choosing Associates Surgery Center (ASCO). Dr. James Lowe and his staff will do their best to provide you and your family with excellent care. We ask that you take a few minutes to fill out the enclosed surgery forms and bring them back the day of surgery. Also, if applicable, bring a copy of your current medication list and any outstanding laboratory results as it will make the process easier the day of your surgery.

We try to schedule your surgical date, time, and location based on your specific needs. We will do our best to accommodate all your clinical concerns and special request. If you are considering adding another procedure to your surgery, please let us know in advance so we can make proper arrangements. If you are coming in to discuss a possible surgery, please note that surgery at ASCO cannot be performed at the time of your consultation. Surgical procedures require evaluation, time allotment, medication modifications, and preparation that cannot always be predicted in advance.

We are very excited for the opportunity to take care of you in the near future, and we will do our best to meet all your expectations. Remember that a $500 fee is required to hold a future surgical date at our facility. Patients scheduled to undergo cosmetic surgery with anesthesia need to pay two weeks in advance of the surgery date. We always welcome your comments and suggestions. If you have any questions about your upcoming visit, please call our Plastic Surgery Coordinator at 405-942-4300.

Warmest regards,

James B. Lowe, MD, FACS
Medical Director, Associates Surgery Center

2520 Northwest Expressway OKLAHOMA CITY, OK 73112
TEL. (405) 942-4300 FAX (405) 942-4312

Associates Surgery Center, LLC (ASCO)

Consent for Admission and Treatment

Consent to Medical Care: I request admission to Associates Surgery Center, LLC (ASCO or Associates Surgery Center) and authorize the facility, staff and physicians to provide care. I request and consent to medical care and diagnostic procedures that my attending physician(s), or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in Associates Surgery Center is under the direction of my attending physician(s) and that Associates Surgery Center is not responsible for acts of omission of my attending physician(s). I authorize Associates Surgery Center to retain or dispose of any specimen or tissue taken from the above named patient.

Teaching Programs: I understand that this Associates Surgery Center is a facility that promotes education opportunities, and therefore, I understand that I may be seen and examined by supervised participants as a part of the educational program. I agree to participate in these programs, but reserve the right to limit my participation at any time.

Disclosure of Information: The undersigned agrees that all records concerning this patient's hospitalization shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that **THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWS AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

Special Consent for HIV Testing: The undersigned specifically consents to the testing of the patient's blood or human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by the patient's attending physician to be necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the facility or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. The undersigned has been informed about the nature of the blood test, its expected benefit, and has been given the opportunity to ask questions about the blood test.

☐ **Do** ☐ **Do Not** I (we) authorize Associates Surgery Center and/or my physician and/or physician to photograph/video or permit other persons to photograph/video for such purposes as may be deemed necessary.

☐ **Do** ☐ **Do Not** I (we) consent to the presence of students, residents or fellows, and vendors in the operating room to observe the procedure. I am aware that only the physician may grant this permission on my consent.

Advance Directives: Associates Surgery Center does not follow any predetermined Advanced Directives. If you have any questions please talk to your physician or anesthesiologist.

Patient Rights: I acknowledge receipt of information explaining my rights as a patient and, on request, I received a copy of the notice and this facility policy statement regarding Patient's Right to Self-Determination.

I have been informed that my physician may be a partner in ownership of Associates Surgery Center. I have the right to review a list of partners.

The Physicians and Allied Health Professionals (AHPs) practicing at Associates Surgery Center are licensed and/or credentialed to practice in this facility. The physicians and AHPs provide medical services at Associates Surgery Center, but they are not agents or employees of Foundation Surgery Center of Oklahoma.

Financial Agreements: For services hereto performed or to be performed for the Patient by Associates Surgery Center (whether one or more), below signed (severally if more than one), whether as patient, agent or guarantor, agrees and promises to pay the charges for the care so provided to the Patient by Associates Surgery Center in accordance with Associates Surgery Center then current standard rates and all costs incurred in collecting same, together with attorney's fees, which Associates Surgery Center deems necessary and reasonably required to enforce the rights of Associates Surgery Center LLC.

[Place label here]

Assignment of Insurance Benefits to Associates Surgery Center. As or on behalf of the Insured under the insurance specified on the registration documents of the Patient, and otherwise payable thereto (the present and future rights thereto and monies due or to become due therefrom termed "Contract Rights"), the below signed irrevocably assigns and transfers to Associates Surgery Center of Oklahoma the Contract Rights, and orders and directs such insurer(s) to pay all monies due or to become due thereunder directly to Associates Surgery Center or its assignee. To effect such payment, Associates Surgery Center is irrevocably constituted and appointed lawful attorney in fact with substitution power, to sue or otherwise collect and settle any claim under the Contract Rights as insured without further notice or approval of Insured and to endorse in the name of the Insured any check or other instrument for the payment of monies thereunder. Further, I understand that **ANESTHESIOLOGY, PHYSICIAN SERVICES, PATHOLOGY, RADIOLOGY** and some **LABORATORY SERVICES** will bill me separately and assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim.

If Insured receives monies directly from the Insurer(s), same shall be held in trust and immediately transferred to Associates Surgery Center for amounts due. This assignment is irrevocable with interest until full and complete payment of all monies due to the Facility and its affiliates from this event of admission or otherwise. Money received by Associates Surgery Center from Insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered to the Patient. If charges not covered by insurance cannot be paid in full when due, below signed agrees upon request to sign a promissory note bearing interest at the maximum legal rate to pay all debt not paid, if credit is approved.

Unborn Child Coverage: If pregnant, the above consent for treatment, releases, assignments, and guarantor agreement apply to my newborn child if born at this facility during this period of treatment.

Insurance Precertification: I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Medicare Assignment, Patient's Certification, Authorization to Release Information and Payment Request:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

Acknowledgement of Notice of Privacy Practices: A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is available on request at the Facility. By signing below you acknowledge that you have been provided a copy of the Facility's Notice of Privacy Practice.

I GIVE PERMISSION for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. ☐ **Yes** ☐ **No**

☐ **Limited disclosure to persons listed below:**

Name: _____

Name: _____

Name: _____

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS "CONDITIONS OF ADMISSION AND TREATMENT" FORM.

PATIENT
SIGNATURE: X _____ Date: _____

WITNESS: X _____ Date: _____

Patient (is a minor _____ years of age) OR is unable to consent because: _____

Relative / Authorized Agent _____

Relationship to Patient: _____ Date: _____

[Place label here]

Associates Surgery Center, LLC – Patient's Bill of Rights and Responsibilities

1. It is the responsibility of the center to know and understand the patient's bill of rights and responsibilities.

2. Upon the patient's admission, admitting personnel and nursing personnel will review the "Patient's Bill of Rights and Responsibilities" statement to each patient or to the legal guardian or significant other in the event the patient is unable to receive the information, and the original document will be maintained in the Medical Records.

3. Effective treatment depends in part on patient's history. The patient, of the patient's family, has an obligation to be open and honest and provide information about past illnesses, hospitalizations, medications, and other pertinent matters.

4. The center expects the patient will ask questions about directions or procedures they do not understand. The patient has an obligation to make known immediately if they do not understand the instructions given them concerning their health, or if they think they will not be able to comply with such or other instructions.

5. The patient has a right to address concerns regarding the quality of their care to the facility staff.

6. The center expects the patient to be considerate of other patients and staff in regard to noise, smoking, and number of visitors in the patient areas. The patient is also expected to respect the property of the center and of other persons.

7. To help the patient's physicians and the center staff care for the patient, the patients are expected to follow instructions and medical orders and report unexpected changes in their condition to their physician and staff.

8. The patient has an obligation to maintain personal and financial integrity with respect to the health care services provided on their behalf.

9. The patient assumes financial responsibility for all services either through their insurance or by paying at or before the time of service.

10. The patient has a right to examine and receive an explanation for their billing statement, regardless of the source of payment.

11. The patients are expected to follow safety regulations that they are told or read about.

13. The patient is responsible for following the treatment plan recommended by the practitioner responsible for their care. If the patient fails to follow their healthcare provider's instructions, or if the patient refuses care, they are responsible for their own actions.

14. A patient has the right to respectful care given by competent personnel.

15. A patient has the right, upon request, to be given the name of his attending practitioner, the names of all other practitioners directly participating in his or her care and the names and functions of other health care persons having direct contact with the patient.

16. The patient has the right to every consideration of their privacy concerning their own medical care program. Case discussions, consultation, examination, and treatment are confidential and should be conducted discretely when possible. Those not directly involved in the patient's care must have the permission of the patient to be present.

17. A patient has the right to have records pertaining to his or her medical care treated as confidential except as otherwise provided by law or third party contractual arrangement.

18. A patient has the right to know what center rules and regulations apply to his or her conduct as a patient, and the patient has an obligation to respect the policies of the center.

19. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.

20. The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.

21. The patient has the right to full information in layman's terms, concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his or her behalf to the responsible person or persons.

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS FORM. The surgeon has disclosed the comparative risks, benefits, and alternatives associated with performing this procedure in this independently certified (Non-state Certified) surgical facility instead of in a hospital or other location.

Patient (is a minor _____ years of age) AND/OR is unable to consent because: _____

Patient / Relative / Authorized Agent	**Relationship to Patient**	**Date / Time**
Witness Signature	**Staff (Printed)**	**Date / Time**

Copy should be provided to Patient at request

ASSOCIATES SURGERY CENTER, LLC (ASCO)

CONTACT INFORMATION:

Please leave a name & phone number of the person that is with you and will be taking you home. List the person for us to contact after surgery.

*You are required to have a ride home arranged prior to having surgery & you may not drive yourself home after surgery

** Patients ride agrees to arrive at the requested time for instructions & pickup

*** Patients are not allowed to stay overnight in this facility

Name (s):

Phone Number:

Secondary Number:

HOME IMFORMATION:

This is helpful for Dr. Lowe for follow-up calls or in case of emergency. It is required for patients who have requested a home health nurse in advance. Please, leave the contact name & phone number of the person that will be staying with you overnight if different then above.

Primary Overnight Contact & Number:

Address where staying:

Directions if Home Nurse:

ASCO Administrative Area

Contact Time: _____

Patient Family Contacted: _____

Staff Member / Physician Signature: _____

Anesthesia Questionnaire (ASCO)

(Patient Label Here)

Surgeon: James B. Lowe, MD, FACS

Patient Chief Complaint:_____

Date:_____ Age_____ _X_ Preoperative _X_ Outpatient

1. Heart Disease/Trouble.	Yes	No	50. Any false, loose teeth, or bridges?	Yes	No
2. Abnormal EKG.	Yes	No	51. Wear contact lenses?.	Yes	No
3. Congestive Heart Failure.	Yes	No	52. Have you donated blood for yourself?	Yes	No
4. Pacemaker/Implanted Defibrillator.	Yes	No	53. Have you ever had a blood transfusion?	Yes	No
5. Heart Valve Replacement.	Yes	No	54. Do you object to a blood transfusion?	Yes	No
6. High/Low Blood Pressure.	Yes	No	55. Other:_____		
7. Swelling Ankles/Feet.	Yes	No	56. Date/Time of last Food & Drink._____		
Asthma.	Yes	No	57. Have you had any recent illness?	Yes	No
9. Bronchitis/Emphysema.	Yes	No	58. Any esophagus or stomach altering surgery?	Yes	No
10. Abnormal Chest X-Ray.	Yes	No	59. Hysterectomy or tubal ligation?	Yes	No
11. Tuberculosis.	Yes	No	**Previous Anesthetic History**		
12. Oxygen at Home.	Yes	No	1. Date of last anesthetic: _____		
13. Stroke.	Yes	No	2. Any abnormal reactions?	Yes	No
14. Paralysis: __(R) ___(L).	Yes	No	3. Relatives with abnormal reactions to anesthesia?	Yes	No
15. Slurred Speech.	Yes	No	4. Comments:_____		
16. Difficulty Swallowing.	Yes	No	**Previous Surgical/Invasive Procedure (Type/Date)**		
17. Digestive Problems (GERD).	Yes	No	1._____		
18. Blood Vessel Disease (Phlebitis, etc.).	Yes	No	2._____		
19. Abnormal Bleeding Tendencies.	Yes	No	3._____		
20. Anticoagulant Treatment.	Yes	No	4._____		
21. Blood Disease (Anemia).	Yes	No	5._____		
22. Seizures/Epilepsy.	Yes	No	6._____		
23. Numbness of arms and/or legs.	Yes	No	**List of Medications Your Are Presently Taking**		
24. Muscle Weakness.	Yes	No	(Include Supplements/Herbals/Vitamins/OTC)		
25. Fractured: __Facial Bones __Neck __Back.	Yes	No	**Aspirin – How Many a Day:**_____		
26. Joint Replacements.	Yes	No	__SEE ATTACHED LIST		
27. Back Trouble.	Yes	No	Drug Dose Freq. Last Dose		
28. Glaucoma/Cataracts.	Yes	No	1._____		
29. Mononucleosis.	Yes	No	2._____		
30. Jaundice/Hepatitis.	Yes	No	3._____		
31. Kidney Disease/Dialysis/Schedule:_____	Yes	No	4._____		
32. Diabetes.	Yes	No	5._____		
34. Positive HIV/AIDS Blood Test.	Yes	No	6._____		
35. MRSA Infection.	Yes	No	7._____		
36. Cancer/Location:_____	Yes	No	**List Allergies (Drug, Food, i.e. Peanuts, Shellfish)**		
37. Arthritis.	Yes	No	1._____ 6._____		
38. Thyroid Problems.	Yes	No	2._____ 7._____		
39. Motion Sickness.	Yes	No	3._____ 8._____		
40. Smoke/Pkg/Day_____ How Long?_____	Yes	No	4._____ 9._____		
41. Alcohol Use/How Often?_____.	Yes	No	5._____ 10._____		
42. Recreational Drug Use (Street Drugs).	Yes	No	Reactions to Latex, Band-aids, balloons, tape, rubber gloves, or		
43. Sleep Apnea History.	Yes	No	other elastic products.:_____	Yes	No
44. Excessive Daytime Sleepiness.	Yes	No			
45. Loud Snoring.	Yes	No	Patient Signature:_____		
46. Are you pregnant?	Yes	No	Nurse Signature: _____		
47. Are you Breastfeeding?	Yes	No			
48. Any Body Piercing?	Yes	No	**HOSPITAL USE ONLY:** Vitals: Time:		
49. Immunizations: __Flu Shot __Pneumovax.	Yes	No	Weight: _____kg Height: _____in. BMI_____		
__Tetanas __Hep A __HepB ___H1N1			Temp_____ BP_____ P_____ R_____ O2_____		

Anesthesia Evaluation (for Anesthesiologist Use)	Post Anesthesia Evaluation
1. General Appearance: _____	Time: _____AM/PM___
2. Sensorium: __AA&O __Drowsy __Confused __Age Appropriate _____	
3. Head & Neck: __WNL_____	Status: __Stable __AA ___Drowsy
4. Cardiovascular: __RRR __Murmur _____	__Under Effect Anesthetic __Age Appropriate
5. Chest: __BS CTA Bilaterally __Wheezing _____	
6. Abdomen: __WNL __Distended _____	Vital Signs: BP_____ SpO2_____ P_____
7. Extremities & Back: ___WNL _____	RR_____ Temp_____
8. Skin: __p/w/d __Intact __Pale __Diaphoretic _____	Respiratory: __Regular/Unlabored/Symmetrical
9. I.V. Infusion: ___Patient Site:_____	__Shallow/Symmetrical __Intubated __Flow by
Risk, Benefits & Alternatives Discussed in full	Cardiovascular: __RRR __Other_____
Anesthesia Plan: __General __Regional __Spinal __Local __MAC/TIVA	Comments:
Understands & agrees to Anesthetic Plan ASA: __1 __2 __3 __4 __5 __E	_____
_____AM/PM_ _____	_____
Date Time Anesthesiologist	_____