CHART AUDIT TOOL

The chart is reviewed for completeness by reviewing all forms for data, times, signatures. If a form is not appropriate for a particular case, place a check in the N/A (not applicable) box. If a chart is deficient in any area, it will be flagged for review by the administrator.

<table>
<thead>
<tr>
<th>Item</th>
<th>DEPT</th>
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<tbody>
<tr>
<td>Advanced Directives</td>
<td>Business</td>
</tr>
<tr>
<td>HIPPA policy and practice (top/right side/3rd page)</td>
<td>Business</td>
</tr>
<tr>
<td>Patient Demographics (left/business side)</td>
<td>Business</td>
</tr>
<tr>
<td>Physician Orders for Procedure (Scheduling form-top left side)</td>
<td>Business</td>
</tr>
<tr>
<td>Consent for Procedure (top/right side)</td>
<td>Pre-Procedure</td>
</tr>
<tr>
<td>Physician Orders <strong>SIGNED</strong></td>
<td>Pre-Op</td>
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<tr>
<td>History &amp; Physical</td>
<td>Pre-Op</td>
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<tr>
<td>Pre-Op Phone call (Pre/Post op/discharge)</td>
<td>Pre-Op</td>
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<tr>
<td>Pre-Op Assessment (Pre/Post op/discharge)</td>
<td>Pre-Op</td>
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<tr>
<td>Consent for Procedure <strong>SIGNED</strong></td>
<td>OR</td>
</tr>
<tr>
<td>Physician’s Orders <strong>RN signed off</strong> (MD signed)</td>
<td>OR</td>
</tr>
<tr>
<td>Procedure Record (locals only)</td>
<td>OR</td>
</tr>
<tr>
<td>Miscellaneous (req for specimens, etc.)</td>
<td>OR</td>
</tr>
<tr>
<td>Post Operative note (progress notes)</td>
<td>PACU</td>
</tr>
<tr>
<td>Discharge Instructions</td>
<td>PACU</td>
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<tr>
<td>Procedure Record (locals only)</td>
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<tr>
<td>Miscellaneous (audit tool)</td>
<td>PACU</td>
</tr>
<tr>
<td>Post-Op Phone Call form</td>
<td>RN</td>
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</tbody>
</table>

Date of Audit _______________ Completeness of signatures _______________

<table>
<thead>
<tr>
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<td>PACU</td>
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</tr>
</tbody>
</table>
PRE-PROCEDURE RECORD

DATE: _______ TIME TO PREOP: _______ PROCEDURE: ________________________________________

PT. BELONGINGS DISPOSITION: ________________ RESP. ADULT: ____________________________

ALLERGIES: ____________________________________________________________

HEIGHT: _______ WEIGHT: _______ LAST PO INTAKE: ________________________________________

MEDS TAKEN TODAY: ________________________________________________________________

PAIN ASSESSMENT: _________________________________________________________________

ADMISSION VITAL SIGNS

BP: ____/____ PULSE: _____ RESP: _____ O2 SAT: _____ % TEMP: _____ FS: _____ UPT: _____

LOC: □ A&OX3 □ AGE APPROPRIATE □ OTHER: __________________________________________

SKIN: □ WARM & DRY □ OTHER: ______________________________________________________

LUNGS: □ WNL □ OTHER: ____________________________________________________________

CARDIAC: □ WNL □ OTHER: __________________________________________________________

OTHER: □ ________________________________________________________________

DENTURES REMOVED VALUEABLES/DISPOSITION_____________________________________

IV SIZE/TYPE: ___________ SITE: _____________

PRIMARY SOLUTION/VOLUME/RATE: ________________________________________________

PRE-PROCEDURE MEDS: _____________________________________________________________

SAFETY MEASURES ADDRESSED: □ Bed in low position and locked. □ Call bell and side rail up if patient unattended)

________________________________________________________

SIGNATURE: ___________________________ DATE: ___________ TIME: ___________
INFORMED CONSENT TO OPERATION AND OTHER MEDICAL SERVICES INCLUDING TRANSFUSION(S)

**The facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of the facility, but independent contractors and therefore are the patient’s agents or servants. The facility provides nursing and support services and facilitates; the facility does not provide medical physician care. **The procedure(s) listed to be performed and the advantages and disadvantages, risks and possible complications as well as the alternatives have been explained to me by my physician. The physician has satisfactorily answered my questions. My consent is given with the understanding that any operation or procedure involves risks and hazards. The more common risks include: infection, bleeding with or without the need for blood transfusions, nerve injury, injury to surrounding structure, wound healing complication, DVT, PE, heart attack, stroke, allergic reaction, damage to teeth or bridgework, pneumonia, other ______________________. These risks can be serious and possibly fatal. I authorize and direct the above-named surgeon to arrange for such additional services for me as he/she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of pathology or radiology services, to which I hereby consent. I authorize the pathologist or physician to use his/her discretion in disposing of any member, organ, implant, prosthetic, or tissue removed from my person during the operation(s) or procedure(s).

**Risk of surgery include but are not limited to the following: Bleeding, infection,**

**In the event of any accidental exposure of any blood or bodily fluid to a physician, contractor or employee of the facility, I consent to testing for HIV and Hepatitis.**

**I understand that it is my responsibility and that I have arranged for a responsible adult to drive me home and remain with me following my surgery. I acknowledge that I have been advised by facility personnel not to drive until all effects of medication have worn off. I understand this to mean that I should not drive until the day after my surgery / procedure or as directed by my physician.**

**I hereby consent to the presence of other person(s) for the purpose of assisting the physician during the operation/procedure, and education.**

**I hereby consent to intraoperative photography for the purpose of education/training and legal documentation.**

**I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility.**

**I understand that if I am pregnant or if there is any possibility that I may be pregnant, I must inform the facility immediately since the scheduled operation / procedure could cause harm to my child or myself.**

**I am aware that my physician may have an ownership interest in the facility, and I acknowledge that I have a right to have the operation / procedure performed elsewhere.**

**I understand that in the rare event that hospitalization is required during or immediately after the surgery, my physician will arrange for my transfer to a local hospital.**

**My signature below constitutes my acknowledgement that:**

1) I have read or have had read to me the foregoing and I agree to it.
2) The operation(s) / procedure(s) has been adequately explained to me by my physician.
3) I authorize and consent to the performance of the operation(s) / procedure(s) and any additional procedure(s) deemed advisable by my physician in his/her professional judgement.
4) I authorize and consent to the administration of anesthesia for the said operation(s) / procedure(s).

******If I am not the patient, I represent that I have the authority of the patient, who, because of age or other legal disability, is unable to consent to the matters above. A) I have full right to consent to the matters above, and consent to same; B) I hereby indemnify and hold harmless the facility, its employees, agents, medical staff, partners and affiliates from any cost or liability arising out of my lack of adequate authority to give this consent.

Date: __________________________ Time: ________________ Patient Signature: __________________________
Date: __________________________ Time: ________________ Witness to signature: __________________________

If patient is a minor or unable to sign, please complete the following:

Patient is unable to sign because: ☐ Patient is a minor ☐ Other: __________________________

Date: __________________________ Time: ________________ Patient Signature: __________________________
Date: __________________________ Time: ________________ Witness to signature: __________________________

PHYSICIAN’S AFFIRMATION OF CONSENT: I certify that I have informed the patient or his/her representative of the nature of this operation / procedure, alternative methods thereto, including non-treatment, and the risks associated therewith.

Physician Signature: __________________________

TSC 0909529
Post Operative Phone Call

Phone #:______________________________________
Procedure:____________________________________

Inquire of the patient:

Tolerating food and liquids?  □ Yes  □ No
Comments: ____________________________________________________________

Nausea and Vomiting?  □ Yes  □ No
Comments: ____________________________________________________________

Pain medication effective?  □ Yes  □ No
Comments: ____________________________________________________________

Dressing Intact?  □ Yes  □ No
Comments: ____________________________________________________________

Drainage?  □ Yes  □ No
Describe: ____________________________________________________________

Swelling, redness at operative site?  □ Yes  Describe: ________________________
□ No

Change in color, numbness, tingling, coldness at site?  □ Yes  Describe: _____________
□ No

Follow up appt. scheduled?  □ Yes
□ No Comments: __________________________________________________________

Referred to Physician?  □ Yes  Comments: _______________________________________
□ No

Comments: ________________________________________________________________
____________________________________________________________________________

□ No Phone  □ No Answer  □ Left Message  □ Spoke to: ______________________________

Date: ___________ Time: _________ By: _____________________________________________
Not contacted, letter sent __________ by _____________________________________________

Record # TSC0000538
Advance Directives / Living Will / Health Care Proxy

I understand that I have the right to make choices regarding life-sustaining treatment (including resuscitative measures). I also understand that my directives will be suspended while undergoing procedures at Timonium Surgery Center.

☐ Yes, I have an Advance Directive / Living Will / Health Care Proxy but did not bring it with me.

☐ No, I do not have an Advance Directive / Living Will / Health Care Proxy.

☐ I wish to have information on how I can obtain an Advance Directive / Living Will / Health Care Proxy.

_______________________________________  ________________________________________
Print Name      Signature

_______________________________________
Date
Dear Patient:

Thank you for scheduling your procedure at TIMONIUM SURGERY CENTER, LLC. Your physician and his partners designed this center with their patients in mind, and we are proud to serve you here.

Although TIMONIUM SURGERY CENTER is not a participating provider with your insurance plan, please be assured that you will not incur any “out-of network” costs or penalties for using our facility. It is our policy to extend “in-network benefits” to all of our patients.

It is possible that the insurance payment for your visit with us today will be sent to you and payable to you. Your insurance company is assuming that since we are out-of-network with them, you are paying for your procedure today. The check that they send to you is “reimbursement” for that payment.

We ask that you endorse the check over to Timonium Surgery Center and mail it to us, take it to your physician’s office, or bring it directly to the center. Please provide a copy of the Explanation of Benefits (EOB) that accompanies the insurance check. Providing a copy of the EOB will allow us to properly credit your account, and make the necessary adjustment off of your bill to match your in-network benefits. After all adjustments are made, you will receive a statement from our billing company showing payments and balance due, if any.

Failure to provide us with payment made by your insurance carrier on your behalf for today’s procedure could result in the following:

_________ Will be reported to the proper authorities as insurance fraud and/or theft.
INITIAL

_________ Will be reported to the IRS as income you received.
INITIAL

_________ Will result in you owing the entire balance due for today’s procedure.
INITIAL

_________ In the event of an appeal for insurance claim payment, I am requesting that
INITIAL
Timonium Surgery Center file an appeal with my insurance carrier on my behalf.

If you have any questions or concerns, please do not hesitate to call our billing office at (410)560-3301, or via email at igreen@timoniumsurg.com, between the hours of 8:30am – 4:00pm Monday through Friday.

___________________________________   _______________
Patient Signature       Date

___________________________________   _______________
Witness Signature       Date

cc: Billing
AUTHORIZATIONS AND DISCLOSURES

These AUTHORIZATIONS MUST BE SIGNED BY THE PATIENT (or by the party legally responsible for a minor or physically or mentally incapacitated patient), and by the party financially responsible for the patient, if other than the patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

1. **AUTHORIZATION FOR MEDICAL TREATMENT**: Each of the undersigned hereby authorize any anesthesia, medical or surgical treatment and Timonium Surgery Center, LLC service rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated for purposes and diagnosis, treatment and medical care. No promise, guarantee or warranty has been made regarding the results of any medical treatment or surgical procedure. Any and all removed organs or parts may be disposed of in accordance with accepted medical practices.

2. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**:
   a) For Purpose of reimbursement: Timonium Surgery Center and each attending or treating practitioner, including if applicable, PATHOLOGY, ANESTHESIA, and/or RADIOLOGIST, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, to my insurance companies, and other organization, third party payers, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. WE UNDERSTAND THAT SUCH DISCLOSURES MAY CONTAIN INFORMATION WHICH COULD RESULT IN LIMITATION OR DENIAL OF INSURANCE BENEFITS OR THIRD PARTY REIMBURSEMENT OR WHICH COULD OTHERWISE BE HARMFUL OR PREJUDICIAL TO MY (OUR) INTERESTS. Nevertheless, each of the undersigned do hereby release and hold Timonium Surgery Center, its officers, directors, agents and employees, and all examining and treating practitioners harmless of and from any and all costs, loss, damage, or liability resulting from and such disclosures(s).
   b) To Family and Responsible Party: Timonium Surgery Center and each attending or treating practitioner, UNLESS SPECIFICALLY INSTRUCTED OTHERWISE BY DELETING THIS SUBPARAGRAPH 2(b), are hereby authorized and directed, during the period of this admission, to consent to treatment pursuant to 431.061-.065, RSMO (1979) as amended, concerning the patient’s health status, diagnosis, prognosis and progress. Each of the undersigned do hereby release and hold Timonium Surgery Center, its officers, directors, agents employees, and all examining and treating practitioners harmless of and from any and all costs, loss, damage, or liability resulting from or arising out of such disclosure.

3. **RELEASE OF RESPONSIBILITY FOR VALUABLES**: Timonium Surgery Center is hereby fully released of and from any and all responsibility for loss of damage to the personal property, money, or valuables of the undersigned patient.

4. **NOTICE OF PRIVACY PRACTICES**: I am aware of my rights to privacy of personal health information, under the Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

5. **PHYSICIAN OWNERSHIP DISCLOSURE**: Timonium Surgery Center provides services only to patients admitted by private practitioners who are members of the Timonium Surgery Center medical staff, some of whom retain joint ownership of the Timonium Surgery Center.

6. **FLAT RATE FEE**: Timonium Surgery Center charges a flat rate global fee for surgical services.

7. **TERMS FOR TREATMENT & FINANCIAL RESPONSIBILITY**: I understand that treatment deposit and/or acceptable hospitalization insurance is required for treatment in Timonium Surgery Center. Total balance is due on the day of surgery, with allowance made for insurance coverage APPROVED AND VERIFIED PRIOR TO TREATMENT. In accordance with above terms, and in consideration of Timonium Surgery Center, its agents or assigns, whatever the sums of money that shall become due on the account of the patient and that such liability shall be joint and several. It is agreed that if full payment is not made by insurance or other third party payers within thirty (30) days, the undersigned shall make payment in full. ANY PAST DUE BALANCES NOT PAID BY INSURANCE OR OTHER 3rd PARTY PAYER, SENT TO A COLLECTION AGENCY IS THE RESPONSIBILITY OF THE GUARANTOR AND HE/SHE AGREES TO PAY ALL COLLECTION FEES OR COURT COSTS.

8. **MEDICARE/CERTIFICATION AND AUTHORIZATION**: Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable is correct. Any holder of medical or other
information about the patient pertaining to this admission, is authorized to the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient’s behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

9. **ASSIGNMENT OF INSURANCE AND THIRD PARTY BENEFITS:**

a) **To the Timonium Surgery Center:** The undersigned, and each of them, do hereby assign, transfer, and set over unto Timonium Surgery Center all benefits payable to them or either of them now due and to become due and payable, including major medical benefits, by reason of this admission under any policy of insurance or other health care coverage in which the patient is a covered beneficiary.

b) **To the Health Care Provider:** The undersigned parties do hereby assign, transfer, and set over unto the patient’s health care providers, including their professional corporations or business entities, including without limitation, if applicable, Pathology Provider, Anesthesia Provider and Radiology Provider, all benefits otherwise payable to the undersigned now due and to become due and payable, including major medical benefits, by reason of this Timonium Surgery Center admission under any policy or other health care coverage contract in which the patient is a covered beneficiary.

c) **To Medicare:** The undersigned parties do hereby assign, the transfer and set over any and all Medicare benefits payable for Timonium Surgery Center and health services relating to this admission to corporations or business entities, including but not limited to, if applicable, Pathology Provider Name, Anesthesia Provider Name, Radiology Provider Name and hereby authorize Timonium Surgery Center and said health care providers or their corporations to submit claims directly to Medicare for payment on behalf of the undersigned patient, items not covered by Medicare will be the responsibility of the undersigned financially responsible party.

I acknowledge that I have been provided information related to Timonium Surgery Center’s policy on Advanced Directives, Bill of Rights and Physician Ownership prior to my scheduled surgery.

THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.

DO NOT sign these authorizations without a full understanding of each.

_____________________________________________________________________
NAME OF PATIENT (PRINT)                         DATE

_____________________________________________________________________
NAME OF AUTHORIZED REPRESENTATIVE TO DISCUSS ABOVE NAMED PATIENT’S MEDICAL AND/OR FINANCIAL ISSUES IN THEIR ABSENCE.       DATE

_________________________________________                 ______________________
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE OR FINANCIALLY RESPONSIBLE PARTY           DATE       RELATIONSHIP

_____________________________________________________________________
WITNESS            DATE
NOTICE OF PRIVACY PRACTICE
INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)
EFFECTIVE APRIL 14, 2003

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.

Timonium Surgery Center, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Timonium Surgery Center, LLC; please see the contact information at the end of this document.

I. HOW ASC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION:

ASC collects and protects the privacy of your health information. The law permits Timonium Surgery Center, LLC (TSC) to use or disclose your health information for the following purposes:

1. **TREATMENT**: TSC may use your health information to provide you with medical treatment or services. For example, information obtained from you by a front office personnel or nurse is necessary to determine what treatment you should receive.

2. **PAYMENT**: TSC may use and disclose health information about you for payment for treatment and services that you receive. For example, your health information may be sent to a third party payer such as an insurance company or health plan in order for TSC to receive payment for services rendered.

3. **HEALTH CARE OPERATIONS**: TSC may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to: evaluate the performance of our staff; assess the quality of care and outcomes in your cases and similar cases; and to determine how to continually improve the quality and effectiveness of health care we provide.

4. **INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION**: You may give us written authorization to use or disclose your health information.

5. **NOTIFICATION AND COMMUNICATION WITH FAMILY**: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable to unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. **REQUIRED BY LAW**: As required by law, we may use and disclose your health information. For example, TSC may disclose health information for the following reasons: judicial and administrative proceedings; to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order of subpoena and other law enforcements purposes; to the Department of Health and Human Services to determine if we are in compliance with federal laws; or to appropriate persons in order to prevent or lessen a serious and imminent threat to the health and safety of a particular person or the general public.

7. **PUBLIC HEALTH**: As required by law, we may use and disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; to aid with disaster relief; and reporting disease or infection exposure.

8. **HEALTH OVERSIGHT ACTIVITIES**: We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

9. **DECEASED PERSON INFORMATION AND ORGAN DONATIONS**: We may disclose health information to coroners, medical examiners, and funeral directors or to organizations involved in procuring, banking or transplanting organs and tissues. (Continued on back side)
10. **RESEARCH:** We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

11. **WORKER’S COMPENSATION:** We may disclose your health information as necessary to comply with worker’s compensation laws.

12. **MARKETING:** We may contact you to give you information about treatments or health-related benefits and services that may be of interest to you.

13. **GOVERNMENT FUNCTIONS:** Specialized government functions such as protection of public officials or reporting to various branches of the armed services may require use or disclosure of your health information.

14. **APPOINTMENTS:** TSC may use your information to provide appointment reminders by phone, email or postal service.

15. **BUSINESS ASSOCIATES:** We work with other businesses to help TSC operate successfully. We may disclose your health information to these business associates so that they can perform the tasks we hired them to do. Our business associates must guarantee us that they will respect the confidentiality of your personal health information.

II. WHEN ASC MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice of Privacy Practices; TSC will not use or disclose your health information without your written authorization.

III. YOUR HEALTH INFORMATION RIGHTS

1. You have the right to request restrictions on certain uses and disclosures of your health information. TSC is not required to agree to the restriction that you requested.

2. You have the right to receive your health information through reasonable alternative means or at an alternative location. Requests must be made in writing detailing the alternative methods chosen and could be applicable to fees.

3. You have the right to inspect and/or obtain a copy of your health information for a reasonable fee.

4. You have the right to request that TSC amend your health information that is incorrect or incomplete. TSC is not required to change your health information and will provide you information about the denial process.

5. You have the right to receive an accounting of disclosures of your health information made by TSC except that TSC does not have to account for the disclosures described in treatment, payment, healthcare operations and government functions of section I of this Notice. The first accounting of disclosures within a twelve-month period is free. Any additional accountings in that time frame are subject to a fee.

6. You have a right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.

7. You have a right to obtain a paper copy of this Notice upon request.

IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

TSC reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, TSC is required by law to comply with this Notice. A paper copy of the Notice is available if you request a copy.

V. COMPLAINTS

If you believe that your privacy rights have been violated or if you have complaints about this Notice of Privacy Practices, contact: Timonium Surgery Center, LLC 1954 Greenspring Drive, LL18 Timonium, MD 21093 PHONE: (410) 560-3301 If you are not satisfied with the manner in which TSC handles a complaint, you may submit a formal written complaint to the Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.

______________________________  ______________________________
PATIENT/REPRESENTATIVE SIGNATURE  DATE
At Timonium Surgery Center, LLC patient satisfaction is extremely important to us. We would be grateful if you would take a few moments to answer the following questions so that we can continue to provide superior care to you and your family. If you feel we have any areas that need improvement, please share that as well. We value your input.

1. Was your wait time acceptable? ACCEPTABLE UNACCEPTABLE
   If unacceptable, please explain: ________________________________________________________________

2. Would you recommend Timonium Surgery Center to family/friends?
   ☐ YES ☐ NO
   If no, please explain: ________________________________________________________________

3. Do you feel your patient confidentiality was maintained during admission?
   ☐ YES ☐ NO

4. Were you kept informed of any delays?
   ☐ YES ☐ NO

5. Please rate your level of pain upon discharge from the surgery center:
   No Pain Intolerable
   0  1  2  3  4  5  6  7  8  9  10

6. Do you feel you received clear and complete instructions regarding how to care for your condition at home, including signs and symptoms of potential problems to watch for?
   ☐ YES ☐ NO

7. Was the nursing staff responsive to you and your family’s needs?
   ☐ YES ☐ NO

8. Was the environment clean and comfortable?
   ☐ YES ☐ NO

9. Please rate your overall experience:
   Excellent Very Good Good Fair Poor

10. Is there anyone you would like to recognize for superior care?
    ☐ YES ________________________ ☐ NO

   PLEASE FEEL FREE TO OFFER ANY OTHER SUGGESTIONS OR COMMENTS:
OR EYE RECORD

Proposed Procedure: ____________________________________________________________

Pre-op Diagnosis: _______________________________________________________________

Pre Op Assessment ID: □ Self & Armband □ Chart □ MD □ Procedure □ Consent

Pre Op Assessment verified by: ___________________________________________________

NPO Status: ________________

Allergies: ____________________ ASA: 1 2 3 4 Wound Class: 1 2 3 4


Fire Risk □ 1 □ 2 □ 3 □ 4

Sterility Indicators: □ Package Integrity checked □ Sterilization tape turned appropriately □ Internal indicators turned appropriately

SCD: □ Y □ N Site: □ Bilateral lower legs □ Right lower leg □ Left lower leg

Bipolar: □ N/A □ Millenium Stellaris TSC #154 □ Infiniti TSC #158 □ Setting ______________

Laser: □ Y □ N If yes, see laser log. Patient free from signs/symptoms of laser injury.

Dressings: Eye pad, Eye shield, Transpore tape. □ Right eye □ Left eye

Medications: All medications checked in boxes are administered by surgeon.

Irrigation: □ N/A □ BSS 500ml □ BSS 500ml with 0.3ml epinephrine 1:1,000 □ BSS with 0.5ml epinephrine 1:1,000 and 0.2ml of Vancomycin 500mg □ Other: ____________________

Other: ________________________________________________________________

Maxitrol Route: Topical □ Tetracaine 0.5% Dose: GTTS Route: GTTS

Atropine 1% Dose: GTTS Route: GTTS □ Cornea coat Route: Topical

Microlol Dose: 2ml Route: Intraocular □ Provic Dose: 0.85ml Route: Intraocular □ Topical

Ancef 1g/10ml Dose: 1ml Route: Sunconjunctival □ Vancomycin 500mg/10ml Dose: 1ml Route: Subconjunctival

Dexamethasone 4mg/ml Dose: 1ml Route: Subconjunctival □ Gentamycin 40mg/ml Dose: 1ml Route: Subconjunctival

Viscoat Dose: 0.5ml Route: Intraocular □ ICG Dye 0.2ml Route: Intraocular

Lidocaine 0.5% Dose: GTTS Route: GTTS

**Expected Outcome** – patient will remain injury free. Evaluation: Tolerated procedure with no apparent injury. □ Yes □ No

Surgeon: ____________________________________________ Anesthesiologist: ______________

Assistant: __________________________________________ Others: ______________________________

Scrub: ___________________________________________ Relief: _______________ Time: _______________

Circulator: ________________________________________ Relief: _______________ Time: _______________

Comments: ____________________________________________________________________________

____________________________________________________________________________________

Transfer to PACU: □ Awake and Alert □ Drowsy □ Stretcher □ Side rails up

RN Signature: ____________________ RN Signature: ____________________
**PACU RECORD**

**Surgeon:** Anesthesiologist: Procedure:  
Arrival Time: Airway: [N/A] Nasal ❑ Oral ❑ LMA D/Ced @ Anesthesia: [Local] [MAC] [General] [TIVA] Other:  

**ALLERGIES:**  

**Time** | **BP** | **Pulse** | **Resp.** | **O2 Sat** | **Temp** | **IV Site** | **N/V** | **Pain Level** | **Site, Quality, Intensity** | **Comments** | **Initials**  
---|---|---|---|---|---|---|---|---|---|---|---  

**Aldrete Score**  
**Activity**  
2=Moves all extremities  
1=Moves 2 extremities  
0=Moves 0 extremities  

**Respiration**  
2=Deep Breaths  
1=Shallow Resp.  
0=Apneic  

**Circulation**  
2=BP 0-20% Preop  
1=BP 20-50% Preop  
0=BP 50% Preop  

**LOC**  
2=Awake  
1=Aroussable  
0=Not Responding  

**Color**  
2=Pink  
1=Pale  
0=Dusky  

**Time** | **Medication** | **Dose** | **Route** | **Initials**  
---|---|---|---|---  

**Location/site** | **Dressing** | **CR <3** | **Pulses Palpable** | **Drains** | **Actions Taken** | **Initials**  
---|---|---|---|---|---|---  

**Adm.**  
**D/C**  

**Cardiac:** ❑ RRR ❑ Other:  
**Lungs:** ❑ CTA ❑ Other:  
**Neuro:** ❑ A&OX3 ❑ Other:  

**Upper Extremities:** ❑ N/A ❑ Motor: ❑ Intact ❑ Other:  
**Sensory:** ❑ Intact ❑ Other:  

**Lower Extremities:** ❑ N/A ❑ Motor: ❑ Intact ❑ Other:  
**Sensory:** ❑ Intact ❑ Other:  

**INTAKE**  
**Infused in OR** | **OUTPUT**  
---|---  
IV LR 0.9NSS @ _____ cc/hr | Urine Output  
IV LR 0.9NSS @ _____ cc/hr | Emesis  
PO | Drains  

**TOTAL** | **TOTAL**  
---|---  

**DISCHARGE:** IV D/C @ _____  
Site: ❑ Without redness/swelling ❑ Other:  
Tolerating PO Fluids ❑ Vitals Stable  
Patient & Escort verbalize understanding of d/c instructions.  
D/C via ❑ W/C ❑ Ambulatory ❑ Stretcher ❑ Home ❑ ________________________ @ ________________________ (TIME).  

**RN SIGNATURE** ________________________ **DATE** ________________________
Patient Name: ____________________________________________

Date: ____________________________________________________________

**MEDICARE WAIVER OF LIABILITY**

Provider Name: ___________________ Medicare #: ___________________

Medicare will only pay for services that it determines to be “reasonable and necessary” under Section 1862(A) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under Medicare program standards, Medicare will deny payment for that service. As your physician, I feel that the service listed below is in your medical interest. I believe that, in your case, Medicare is likely to deny payment for this service for the reason stated in the next sentence. I have been notified by my physician that he believes that, in my case, Medicare is likely to deny payment for the service identified below for the reason(s) stated. If Medicare denied payment, I agree to be personally and fully responsible for payment.

1. Medicare does not usually pay for this many visits or treatments
2. Medicare usually does not pay for this service
3. Medicare usually pays for only one rest home visit per mo.
4. Medicare usually does not pay for this injection
5. Medicare usually does not pay for this many injections
6. Medicare does not pay for this because it is a treatment that has yet to be proven effective
7. Medicare does not pay for this office visit unless it was needed because of an emergency
8. Medicare usually does not pay for like services by more than one doctor at the same time period
9. Medicare usually does not pay for this many services with this period of time
10. Medicare usually does not pay for more than one visit per day.
11. Medicare usually does not pay for such an extensive procedure
12. Medicare usually does not pay for like services by more than one doctor of the same or similar specialty
13. Medicare usually does not pay for this equipment
14. Medicare usually does not pay for this lab test

**AUTHORIZATION AND ASSIGNMENT**

To: First Colonies Anesthesia Associates

With the understanding that you will be rendering professional medical services for my treatment and I have voluntarily given consent for such treatment, I agree to the following:

**Authorization and Release Information**

For the purpose of reimbursement of fees for services rendered by you during my treatment, I authorize you to release any necessary information to third party payors, insurance companies, attorneys or other relevant parties to ensure payment for such services. I also acknowledge that the information provided by me regarding health care coverage is true and accurate to the best of my knowledge.

**PRIVACY NOTICE**

The Patient hereby consents to the disclosure of his/her individually identifiable health information by First Colonies Anesthesia in order to carry out treatment, payment, or health care operations. The patient should review First Colonies Notice of Privacy Practices For Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such notice prior to signing this consent form. First Colonies reserves the right to change the terms of its notice of privacy at any time. If First Colonies does change the terms of its notice of privacy the patient may request a copy from First Colonies. The Patient has the right to request that First Colonies further restrict how his/her health information is used or disclosed to carry out treatment, payment, or health care operation. First Colonies is not required to agree to the requested restriction. However, if First Colonies agrees, then such restrictions are binding to the First Colonies. At all times, patient retains the right to revoke this consent in writing. The revocation shall be effective except to the extent that First colonies has already taken action in reliance on the consent. First Colonies may refuse to treat patient if he/she or an authorized representative refuses to sign this form, unless First Colonies is required by law to treat the patient. If the patient signs and then revokes consent, First Colonies may refuse further treatment to patient unless required by law. I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

**ASSIGNMENT OF BENEFITS**

To: First Colonies Anesthesia Associates

It is hereby acknowledged that payments I owe for services rendered by you will be assigned and directed to First Colonies Anesthesia. In the event that third party payors, insurance companies or other entities forward such payment to me, I agree to assign and direct the payments to you immediately upon receipt.

**Guarantee of Payment and Understanding**

I understand that services rendered by you for my treatment at this surgery center will require payment, and I acknowledge complete responsibility for such payment. If determined that no insurance company or third party payor is obligated to pay for such services, or that proceeds from a liability claim will not yield payment for your rendering of professional services to me, I guarantee such payment in full no later than three months from the time of service. I further acknowledge responsibility for payment of deductibles or to the fees not covered by insurers or third payors and that were incurred by me as a result of your treatment. Should this account be forwarded to an agency for an attorney for collection of fees owed by me, I also acknowledge responsibility for payment of all reasonable collection expenses and attorney fees.

Signature of patient/parent/guardian/representative Date & Time Witness

Order#: TSC009787
**PRE-OP STANDING ORDERS:**

1. Start IV with LR @ 100 ml/hr.
2. Other:
3. Glucometer check on all diabetic patients.

**POST-OP:**

1. O2 to maintain Sats >/= 94%, then wean to room air.

**Analgesia:**

- ☐ Toradol ____ mg IV.

**Narcotic Analgesics:**

- ☐ Demerol ____ mg IV q ____ min, prn pain, up to a total dose of ____ mg.
- ☐ Dilaudid ____ mg IV q ____ min, prn pain, up to a total dose of ____ mg.
- ☐ Fentanyl ____ mcg IV q ____ min, prn pain, up to a total dose of ____ mcg.
- ☐ Percocet 1 OR 2 PO X ____, up to ____ po.

**Antiemetics:**

1. Zofran ____ mg IV q ____ min PRN nausea X ____ doses, if ineffective, use:
2. Reglan ____ mg IV q ____ min PRN nausea X ____ doses, if ineffective, use:
3. Phenergan _____ mg. IV q ____ hrs. PRN nausea X ____ doses.
4. Other:

**MAY DISCHARGE FROM PACU WHEN CRITERIA MET.**

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R.N. SIGNATURE/DATE & TIME  
PHYSICIAN SIGNATURE/DATE & TIME
REQUEST FOR ADMINISTRATION OF ANESTHESIA SERVICES

I the patient ___________________________ or ___________________________ patient relative or guardian, acting on his/her behalf, and asking to receive anesthesia during my pending procedure/operation/treatment in order to lessen the pain I might otherwise experience at Timonium Surgery Center, LLC.

- It has been explained to me that all forms of anesthesia involve some risks. Common problems associated with anesthesia may include but not limited to: nausea, vomiting and muscle soreness. Although rare, severe unexpected complications can occur with anesthesia, which include but is not limited to: bleeding, drug reactions, allergic reactions, liver or kidney damage, blood clots, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified. I understand that the type(s) of anesthesia circled at the bottom of this form will be used for my procedure/operation/treatment.

- I understand that medication(s) that I am taking may cause complications with anesthesia and that I should inform my anesthesiologist of any medications including, but not limited to: aspirin, steroids, cold remedies, heart, blood pressure and thyroid medications, narcotics, alcohol, marijuana and cocaine.

- I understand that if I am pregnant, any medication I may receive may have an adverse effect on the baby/fetus and may cause serious damage including birth defects, brain damage, and death of the baby and/or miscarriage. Therefore, I understand I should inform my doctors if there is a chance that I may be pregnant.

- Should the need arise preceding my procedure/operation/treatment or in the post-operative period, I consent to the administration of blood and/or blood products. Further, I understand that despite careful testing and consent to the screening of blood and related products, I may still be subject to the ill effects of a transfusion. The following are some but not all of the potential risks that can occur; fluid overload, fever and allergy reactions, hemolytic reactions, and transmission of diseases; hepatitis, AIDS (HIV), and/or cytomegalovirus (CMV).

- I consent to appropriate tests and treatments that may evaluate better my risk and prepare me for anesthesia associated with my pending procedure/operation/treatment.

- I understand that while I am receiving anesthesia, conditions may develop which require modifying or extending this consent. I therefore authorize modifications or extensions of this consent that professional judgment indicates to be necessary under the circumstances.

- I understand that my anesthesia care will be given to me by or under the supervision of an attending anesthesiologist. I understand that along with my attending anesthesiologist and his/her assistants, designees, and other medical center personnel such as Certified Registered Nurse Anesthetists (CRNA) technicians will be involved in my anesthesia care.

- By signing this request form, I indicate that I fully understand the contents of this document, agree to its provisions, and request the administration of anesthesia for relief of pain during my pending procedure/operation/treatment. I know that if I have concerns, and would like more detailed information, I may ask more questions, and receive more information from my attending anesthesiologist.

- I acknowledge that I know the practices of anesthesiology, medicine, and surgery are not exact sciences, and that no one has given me any promises or guarantees about the administration of anesthesia or its results. I have been informed about the common foreseeable risks as well as reasonable alternatives. I fully understand what I am now signing is on my own free will. All questions regarding anesthesia have been answered to my satisfaction.

- I consent to the following anesthetic Plan: General/TIVA/MAC with sedation/MAC without sedation/Regional.

Signature of patient/parent/guardian ___________________________ Date & Time ___________________________ Witness ___________________________

I, Dr. ___________________________, attest that this patient or the representative named above has been informed about the common foreseeable risks and benefits of the proposed anesthetic procedure(s) as well as reasonable alternatives. Patient questions with regard to the procedure have been answered to his/her apparent satisfaction.

Signature of anesthesiologist ___________________________ Date & Time ___________________________
### INTRA-OP ANESTHESIA RECORD

<table>
<thead>
<tr>
<th>Check list</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anes machine</td>
<td></td>
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<tr>
<td>O₂ supply</td>
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<tr>
<td>Suction</td>
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<tr>
<td>Scavenger sys.</td>
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<tr>
<td>O₂ analyzer</td>
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<tr>
<td>Patient I.D.</td>
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<tr>
<td>Hx &amp; PE</td>
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<tr>
<td>NPO Status</td>
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<td>Pre-induction assessment</td>
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<tr>
<td>Anes. start:</td>
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<tr>
<td>Into OR</td>
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<tr>
<td>Start procedure</td>
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<td>End procedure</td>
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<tr>
<td>PACU</td>
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<tr>
<td>Anes. end</td>
<td></td>
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<tr>
<td><strong>Anesthetic Technique</strong></td>
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<tr>
<td>TIVA Gen Epid Spinal Block</td>
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<tr>
<td>MAC</td>
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<tr>
<td><strong>Airway Maintenance</strong></td>
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<tr>
<td>Natural ETT Mask</td>
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<td>Airway LMA</td>
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<td>Direct vision Atraumatic</td>
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<td>Difficult Blade</td>
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<td>(+)ETCO₂ BBS</td>
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<td><strong>Patient position</strong></td>
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<tr>
<td>Supine Prone Lithotomy</td>
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<td>Lat. decub L R</td>
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<tr>
<td>Eye care</td>
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<tr>
<td>Pressure points padded</td>
<td></td>
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</tbody>
</table>

### POST-ANESTHESIA EVALUATION/ BP  HR  RR  Pox

The vital signs, including blood pressure, heart rate and rhythm, respiratory rate and quality, oxygen saturation, temperature, pain rating and modified Aldrete score have been reviewed and deemed to be appropriate. Additionally, fluid status is appropriate for the surgical procedure. Pain, nausea and vomiting have been appropriately assessed and treated. ☐ The patient was mentally able to participate in this post-op evaluation. ☐ The patient's mental status has returned to pre-op baseline level. ☐ There are no apparent post-anesthesia complications. ☐ Anesthesia complications (Explain).

☐ No apparent post-anesthesia complications  M.D.  Date _______ Time _______

Anesthesiologist signature
ATTESTATION OR REVIEW OF HISTORY AND PHYSICAL

DATE: __________________________   TIME:____________

PRE-PROCEDURE DIAGNOSIS:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

THE INDICATION FOR SURGERY IS AS STATED ABOVE.

THE HISTORY AND PHYSICAL HAS BEEN REVIEWED.

☐ There are no significant changes in the patient’s status which would impact the schedules procedure.

☐ There are no significant changes in the lab values would impact the scheduled procedure.

The following changes have occurred and are discussed below:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

_____________________________________________________________________

PHYSICIAN’S SIGNATURE