Willoughby Surgery Center
6025 Commerce Circle, Suite 1
Willoughby, OH 44094
Phone (440) 585-2750 Fax (440) 944-0868

Cleveland Medical Institute
6025 Commerce Circle, Suite 2
Willoughby, OH 44094
Phone (440) 944-1414 Fax (440) 944-1445

Hours of Operation: Monday through Friday 8:00am to 5:00pm
Please call the day before your procedure between 12:00pm and 4:00pm to receive arrival time (440-585-2750)

Name:_____

Procedure:_____ Anesthesia: ◯Yes ◉No

Your procedure is scheduled to be performed on: _____

Failure to follow these instructions may result in the cancellation of your procedure!

1. It is important to remember that you must have someone to drive you home following the procedure. Failure to do so will result in a cancellation of your procedure. **Driver must present themselves at the front desk.**

2. Bring the following items:
   - Current Driver's License or State ID
   - Demographic sheet (signed)
   - Privacy Practices Form (signed)
   - Advanced Directive/Living Will Form – (optional) (signed)
   - Current Insurance Card
   - Patient Rights/Responsibilities (signed)
   - Privacy Policy (signed)

3. If you are having anesthesia services:
   - If your procedure is scheduled in the **AM or PM**

     i. Eat a larger lunch the day before your procedure and a light supper no later than 7pm.
     ii. Clear liquids may be consumed up until midnight. Take your morning medications as directed with a small sip of water unless instructed otherwise.
     iii. Nothing by mouth the day of the procedure. No candy, mints, gum, smoking, or coffee.
     iv. If you are a diabetic and take oral hypoglycemic medications, **DO NOT** take your diabetic medication the morning of the procedure, If you take injected insulin, take only h the dose of insulin on the morning of the procedure unless instructed otherwise. Please call for specific instructions for your individual instructions regarding diabetic medications and insulins.
     v. All blood pressure medication should be taken the day of the procedure with a **sip** of water in the morning. Avoid diuretics (water pill).

   - **PM procedure patients regarding food and liquids** – food and liquid may be consumed the day prior to your procedure as normal. A small snack may be consumed up until midnight. Clear liquids may be consumed the day of the procedure up until 4:00am.

4. If you are **NOT RECEIVING ANESTHESIA:**
   - You may consume a light meal up to 4 hours **before** your procedure.
   - Take your medications the morning of the procedure with a **sip** of water, unless instructed otherwise.
   - If you have diabetes, take h the dose of your injectable insulin the morning of the procedure, unless instructed otherwise.

5. **TO ALL PATIENTS:**
   - If you take Aspirin, Plavix, Coumadin, or any other blood thinner — we will need written approval from the prescribing physician for you to stop these medications 5 days prior to the procedure, unless otherwise instructed by your physician. ***Failure to provide WSC with written approval may result in the cancellation of your procedure.***
   - If you take Non-Steroidal Anti-inflammatory medications (Motrin - ibuprophen, Aleve, Naprosyn, Mobic) you must stop the medication 2-5 days prior to your procedure — or as instructed.
   - All over-the-counter medications, such as vitamins, supplements, and herbal medications, must be stopped one week prior to the procedure.
   - Abstain from smoking the day of your procedure.
   - Contact your surgeon's office if you are on a special diet.
   - **Shower the morning of your procedure using an antimicrobial soap (Dial).**
   - A nurse from the center will be contacting you within one week of your scheduled surgery.

If you have additional questions, you can call Willoughby Surgery Center at (440) 585-2750. Please bring this pre-procedure instruction sheet with you the day of your procedure. If you must cancel your procedure, please notify/ Willoughby Surgery Center at least 48 hours in advance.

WLLOUGHBY SURGERY CENTER/AMBULATORY ANESTHESIA SERVICES DEMOGRAPHIC SHEET

Last Name:_____ First:_____ Date of Birth:_____

Age:_____ Social Sec#: _____ - _____ - _____ Sex: M or F Home Phone: (_____) _____-_____

Home Address: _____ City: _____

State: _____ Zip: _____ Marital Status: ◉ Sin ◯ Mar ◯ Div ◯ Wid Cell Phone: (_____) _____-_____

Home Mailing Address (if different): _____

Employer Name:_____ Occupation: _____ Work Phone: (____) _____-_____

Employer Address: _____ Employer Phone: (____)_____-_____

Spouse's Name: _____ Spouse's Social Sec#:_____ - _____ - _____

Emergency Contact Person: _____ Relationship: _____ Phone: (____)_____-_____

Name of Referring Doctor: _____ Phone: (____)_____-_____

Primary Care Physician: _____ Phone: (____)_____-_____

Please provide this office with a copy of your Insurance Cards at time of registration

Is this procedure related to an auto accident, work injury, or condition involving legal assistance? _____Yes _____ No

If so, Type of accident: ____Work Injury _____Auto _____Home _____Other Claim #_____

If so, Date of Injury/Accident: ___/____/_____ Fill in Insurance under Primary Insurance

Attorney's Name: _____ Phone: (____)_____-_____

Medicare Insurance #_____ **Medicaid Insurance #**_____

Primary Insurance Carrier Name: _____

Address: _____ City:_____ State:_____ Zip:_____

Phone: (____)_____-_____ Policy #:_____ Group:_____

Name of Person this policy is under:_____

Secondary Insurance Carrier Name:_____

Primary Insurance Carrier Name: _____

Address: _____ City:_____ State:_____ Zip:_____

Name of Person this policy is under:_____

Medical Authorization / Financial Assignment Agreement (Important)

I authorize my holder of my medical information to release this information to Willoughby Surgery Center (WSC) and/or Ambulatory Anesthesia Services (AAS) should they request. I authorize WSC and/or AAS to provide medical services for my condition, and to release any medical information about me to my insurance company. I authorize any holder for request of payments to make payment directly to WSC and/or AAS for services rendered. I will be responsible for any amounts not covered under my insurance plan, including co-pays, deductibles, or any charges not covered by insurance plan. If my insurance is Medicare, or any others with a contract with WSC and/or AAS, WSC and/or AAS will file all claims directly to the carrier on my behalf and WSC and/or AAS will receive payment from the carrier. If my insurance is not contracted with WSC and/or AAS, as a courtesy, WSC and/or AAS will still file a claim with my insurance. carrier. However, if my insurance issues a check to the policy holder for services rendered, I will endorse the check in full to WSC and/or AAS. If there is any outstanding debt that is eventually turned over to a collection agency, I understand that I still will be responsible for the initial debt plus any fees that the collection agency will collect regarding my account with WSC and/or AAS.

I have read the above statement, and understand the credit policy set forth

Patient Signature: _____ Date:_____

Guardian Name: (print) _____ Signature:_____

Willoughby Surgery Center (440) 585-2750

Patient Questionnaire -

Your careful completion of this form will help us provide you with our highest quality of care for your procedure.

Name Age Date of Birth / / ft. in. lbs.

Do you have any Allergies to Drugs, Latex, Iodine, Adhesives, Food, or others? ◉ Yes ◯ No If yes, please list them below.

Allergy to:	Reaction:

Allergy to:	Reaction:

Do you take any medications or herbal supplements? ◉ Yes ◯ No If yes, please list them below.

Medication Name:	Dose	# / day

Medication Name:	Dose	# / day

Your Primary Care Physician:_____ Phone #:_____ Fax #:_____

Dose He/She need to clear you for surgery? ◉ Yes ◯ No

Have you ever had any surgeries? ◉ Yes ◯ No If Yes, please list below.

Type of Surgery	Year

Type of Surgery	Year

Other than for surgery, have you been hospitalized for anything else? ◉ Yes ◯ No If Yes, please list below.

Reason for Hospitalization (Diagnosis)	Year

Reason for Hospitalization (Diagnosis)	Year

VERY IMPORTANT!! I understand that I am not to eat or drink as instructed prior to the Day of Surgery unless instructed otherwise by Willoughby Surgery Center Staff. I also understand that I must have a responsible adult accompany me home after discharge from Willoughby surgery Center.

Date Completed:_____ Signature:_____

---------- Office Use Below ----------

Changes		Date	Changes	Signature
Yes	No	_____	_____	_____
Yes	No	_____	_____	_____
Yes	No	_____	_____	_____
Yes	No	_____	_____	_____
Yes	No	_____	_____	_____

Select Answer **General Questions**

⦿ Yes ○ No Have you or anyone in your family ever had a serious problem with Anestesia?
If Yes, please describe:_____

⦿ Yes ○ No Recent Cold or Flu? Describe Symptoms:_____

⦿ Yes ○ No Do you Smoke? If so, how many packs per day? _____ For how many years?_____

⦿ Yes ○ No Do you use any Recreational Drugs? (Cocaine, Marijuana, etc.) Please list them:_____

⦿ Yes ○ No Do you drink any Alcohol? How many drinks per day? _____ For how many years?_____

⦿ Yes ○ No Any loose Teeth, Caps, Partial Bridges? Describe:_____

⦿ Yes ○ No Any Lung / Pulmonary disease? (Select) Asthma, Bronchitis, Emphysema/COPD
Home Oxygen, Sleep Apnea
If Yes, How many days ago did you have a wheezing episode?_____
Are you now the best you can be? Yes No

⦿ Yes ○ No Shortness of Breath Upon Climbing Up Stairs? How many flights before you must stop to rest?_____

⦿ Yes ○ No Ever have a Heat Attack? If so, when?_____

⦿ Yes ○ No Have you been diagnosed with CHF (congestive heart failure)?
If so, how have you been lately?_____

⦿ Yes ○ No Ever have a Stress Test or Cardiac Catheterization? If so, select which and write dates and results _____

⦿ Yes ○ No Diagnosed with Hypertension? If so, is your doctor pleased with your blood pressure control? Yes No

⦿ Yes ○ No Ever had a TIA or Stroke? If so, what deficits do you have now?_____

⦿ Yes ○ No Ever had Epilepsy or Seizures? If so, when was your last seizure?_____

⦿ Yes ○ No Ever have any Blood Diseases, Anemia, Sickle Cell etc.? Describe:_____

⦿ Yes ○ No Excessive Bleeding or Bruising? Describe:_____

⦿ Yes ○ No Ever diagnosed with Diabetes? Any Complications? Please Describe:_____

⦿ Yes ○ No Any Thyroid Problems? Describe:_____

⦿ Yes ○ No Any Liver Problems? Describe:_____

⦿ Yes ○ No Chronic Headaches, Neck or Back Pain? Describe:_____

⦿ Yes ○ No Weakness / Numbness in a Limb? Describe:_____

⦿ Yes ○ No Ever have Reflux or Hiatal Hernia? How has it been lately?_____

⦿ Yes ○ No Ever diagnosed with Arthritis or Rheumatological Disease? Describe:_____

⦿ Yes ○ No Ever diagnosed with Cancer? Describe:_____

⦿ Yes ○ No FEMALE PATIENTS – Could You Be Pregnant? When was your last normal menstrual period?_____

⦿ Yes ○ No Any other significant Diseases or Information? Describe:_____

Date Completed:_____ Signature:_____

---------- Office Use Below ----------

Changes		Date	Changes	Signature
Yes	No	_____	_____	_____
Yes	No	_____	_____	_____
Yes	No	_____	_____	_____
Yes	No	_____	_____	_____
Yes	No	_____	_____	_____
Yes	No	_____	_____	_____

Willoughby Surgery Center

ADVANCED DIRECTIVES-LIVING WILL

If you have an advance directive or living will, please bring a copy of it with you to the center on the day of your procedure. While you are a patient at Willoughby Surgery Center, your Advanced Directive will not be honored. Should you be transferred to a hospital, a copy of your Advanced Directive will be sent with you.

An Advanced Directive or Living will is used by an individual to indicate their voluntary, informed voice of accepting, rejecting, or choosing among alternative courses of medical treatment.

An Advance Directive or Living Will is document which allows you to give written instructions to those caring for you indicating the type of health care you would wish to receive or reject in the event you become unable to express these decisions yourself.

There are three different types of Advance Directives:

1. **A Proxy Directive-POA**
   This is a document in which a competent adult names a trusted relative or friend to make health care decisions on their behalf when they are unable to make these decisions.

2. **An Instruction Directive-Living Will**
   In this document, the person writing it provides written instructions concerning the type of medical treatment they want or do not want performed for them and under what circumstances.

3. **A Combined Directive**
   In this document, a competent adult stated their general wishes regarding the kind of health care they wish to receive but appoints a trusted relative or friend to carry them out.

If you wish to receive information about Advance Directives you can contact:

Ohio Legal Rights Services
50 West Broad Street, Suite 1400
Columbus, Ohio 43215-5923
Ph-614-466-7264 or 1-800-282-9181

Do you have an **ADVANCE DIRECTIVE or WILL ____ YES _____NO**

If yes, please bring it to the center prior to your scheduled procedure.

Patient's Signature indicating awareness of above:_____

Date:_____

Willoughby Surgery Center, LLC

PRIVACY POLICY

At **Willoughby Surgery Center, LLC**, we respect the confidentiality of your health information and we will protect your information in a responsible and professional manner.

We are required by federal and state laws to make you aware of the following issues that specifically pertain to your treatment, procedures or sessions.

l. You may be issued equipment for your use that will have your full name written on it for purposes of identification.

2. Your surname will be included on a weekly or daily appointment schedule that will be located at the front/receptionist desk.

3. Your patient medical record will be physically placed on the front/receptionist desk with other patient's charts. Your medical record will be physically placed on other staff members' desks as necessary for coordination of care.

4. Your patient medical record will be available to all personnel connected with Willoughby Surgery Center, LLC, as well as your referring physician or practitioner.

5. Your medical record will not be available to anyone not directly connected to your care.

6. Patient progress, consultative or diagnostic reports will be issued by fax or mail to other members of your healthcare team.

7. Your medical or billing chart may be used to submit insurance claims for payment, to obtain insurance pre-certifications/authorizations, for appeals and collections, in cases of medical review, court orders and audits.

8. Sharing of information to any other patient designated agents by fax, e-mail, mail, or by telephone must be specifically authorized by you.

Patient/Guardian Signature:_____

Print Name:_____ Date: _____

Notice of Privacy Practices for Protected Health Information-Willoughby Surgery Center 2/11/08

This form must be read and signed prior to seeing the doctor, due to new federal guidelines, the Health Insurance Portability and Accountability Act (HIPAA), effective 4-14-03. This Notice of Information describes the terms of how your health information may be used and disclosed by Willoughby Surgery Center, how you can gain access to it and also control who else receives or gains access to this information. At the end of this form, you will be asked to sign an acknowledgement of receipt of this notice, as well as to outline or define specific instances or information that you would like to be restricted from disclosure to other entities or specified individuals.

1. **Willoughby Surgery Center (WSC)** may use and disclose your protected health information for treatment, payment, healthcare operations, and other certain circumstances. These include public health requirements, current laws and court orders, worker's compensation, entities assisting in disaster relief, or other similar programs.
2. **WSC** will not make and other use or disclosure of a patient's protected health information without the individual's written authorization. The patient, at any time, can provide a written statement t revise this authorization.
3. **WSC** may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that may be of interest to the individual patient.
4. **WSC** may release protected health information about you to a friend or family member who is involved in your medical care, provided that you list these specific people below who we may speak to regarding your medical care
5. **WSC** reserves the right to change the terms of this notice, making new notice provisions effective for all health protected information that it contains. Copies of these changes/revisions will be given to the patient at next visit, or mailed to the last known address if there is a need to disclose any protected health information.
6. Any person may file a complaint to the Practice and to the Department of Health and Human Services, (800-368-1019) Office of Civil Rights, if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer, Dr. David Demangone, by phone (440) 944-1414, or by mail to Suite 1, 6025 Commerce Circle, Willoughby, OH, 44094. It is **WSC** policy that no retaliatory action will be made individual who submits or conveys a complaint or a suspected or actual non-compliance of the privacy standards.

Patients have been granted individual rights under the HIPAA Legislation, and these include the following:

1. You have the right to inspect and copy protected health information that may be used to make decisions about your care. To inspect and copy your protected health information, you must submit your request in writing to the Privacy Officer listed above. There may be a fee charged to cover the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If so, you may request that the denial be reviewed. A licensed health care professional, but not the one that denied you request, will be chosen by our organization and will review your request and the denial, and make a determination. We will comply with the outcome of the review.
2. If you feel that protected Health Information we have about you is incorrect or incomplete, you have the right to request an amendment for as long as the information is maintained in the designated record set. To do so, your request must be made in and submitted to the Privacy Officer. You must provide a reason that supports your request. If not, your request for an amendment may be denied. We may deny your request if you ask us to amend information that was not created by us.
3. You have the right to request an "accounting of disclosures", a list of the disclosures we have made of your protected health information in addition to those for treatment, payment, or health care operations. The request must be in writing and submitted to the Privacy Officer. The request must address two points; (1) a time period not longer than 6 years or earlier than 4-14-03, (2) in what form you want the list (paper, fax, etc). The first list you request with in a 12 month period will be free. There may be a charge, as determined by us, for additional list, at which time you may withdraw or modify your request before nay cost are incurred. The list will be provided to you in under 60 days of your request, unless we utilize a 30 day extension period.
4. You have the right to request a restriction or limitation on the protected health information we disclose about you for a) treatment, payment, or health care operations, b) to someone who is involved in your care or the payment for your care, like a family member or a friend. However, we are not required to agree to your request. To request restrictions, you must make your request in writing to the Privacy Officer, and you must state (1) what information you may want to limit; (2) whether you want to limit our use, disclosure, or both; (3) to whom the limits apply. Either of us may terminate the restriction after notifying the other.

5. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as at work or by mail. You must make a written request to the Privacy Officer including how or where you wish to be contacted. We will not ask you the reason, and we will try to accommodate your request.

Although Willoughby Surgery Center (WSC) will follow the HIPAA guidelines, as stated earlier, regarding use and disclosure of your health information with other entities, you may further restrict the use and disclosure of you information in any manner you wish, acceptable to WSC, by specifying such restrictions below.

(1) I, _____ request the following restrictions to the use or disclosure of my protected health information in the following manner.

_____

_____

_____

_____

If you wish for certain people, other than yourself, to be able to access your health information, the flowing needs to be completed/described. If you do not complete any further information, then no relatives or friends will be given any information should they request it, other than in an emergency situation.

(2) Willoughby Surgery Center may discuss my medical conditions/information with the following:

(Select) No Yes (If yes, list names)	**NAME**	**Relationship**
Spouse	1)_____	
Parents		
Children	2)_____	
Friends	3)_____	
If more than 4 names, List additional below.	4)_____	

Other:_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received and read WSC's Notice of Privacy Practices.

(Patient or their representative signature)_____ Date_____

If signed by patient representative, their relationship to the patient is _____

Office Use Only: In the event that the patient doesn't sign the acknowledgment, our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below. **(select one)**

(Patient Name)_____ Refused to sign Physically unable to sign

Specific reasons_____

Employee Signature_____ Date_____

WILLOUGHBY SURGERY CENTER

PATIENT RIGHTS

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by the staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
2. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sourced of third party payment or not covered by the facility's basic rate;
3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and functions of these institutions, and to refuse to allow their participation in the patient's treatment;
4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment options, including the option of no treatment, risk(s) of treatment, and expected results. If this information would be detrimental to the patient's health or if the patient is not capable of understanding the information, the explanation shall be provided to his or her of next kin or guardian. This release of information to the next of kin or guardian along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;
6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule, and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination or reprisal;
8. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;
9. To confidential treatment of information about the patient. Information about the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the Ohio State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
10. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;
11. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;
12. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendances at religious services, shall be imposed upon any patient; and
13. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.
14. To contact the Ohio Department of Health, 246 North High St., Columbus OH 43215 or hotline unit @1-800-342-0553 with any concerns or complaints. The web site for the Office of the Medicare Beneficiary Ombudsman is: http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

PATIENT'S RESPONSIBILITIES

1. You, or your family, will provide information about past illnesses, hospitalization, medication and other matters relating to your health history.
2. You will cooperate and follow the care prescribed or recommended for you by your physician, nurses, or allied health personnel.
3. You will notify your physician or nurse if you do not understand your diagnosis, treatment or prognosis.
4. You will advise your nurse, physician, or the nurse manager of any dissatisfaction you may have regarding your care at the facility.
5. You will assume financial responsibility for services rendered, either through third party payors (you insurance company) or through self-payment for services not covered by your insurance company.
6. You will not take drugs which have not been prescribed by your attending physician and administered by the staff; and you will not complicate or endanger the healing process by consuming alcoholic beverages or toxic substances during your stay.
7. You will abide by the facility rules and regulations and be considerate of the rights of other patients and facility personnel.
8. You will be courteous to the treating staff.
9. To have a responsible adult drive you home, and remain with you for 24 hours after your surgery.
10. **Failure to comply with the center's policies may result in dismissal from care at WSC.

****David Demangone, MD, Kurt Schneider MD, Frederic Levine, MD., and Zurab Davili, MD have financial interests in Willoughby Surgery Center.*

_____ _____

Patient's Signature Date

Revised 09/26/18 //wscpatientrights