TEMECULA VALLEY
DAY SURGERY

25495 Medical Center Drive STE 101, Murrieta, CA 92562
951-200-7777

Dear Patient,

Thank you for choosing Temecula Valley Day Surgery and Pain Center for your procedure(s).

Our goal is to make your visit with us as efficient and comfortable as possible. To meet this goal, we have designed this packet of information for you, with forms to complete in advance so that we may serve you better. Your medication list is important. Please make sure ALL prescription and non-prescription drugs are included, and when you last took them.

Temecula Valley Day Surgery and Pain Center is open from 6 am to 6 pm, with occasional extensions of those hours if need arises. We are not open on weekends or holidays.

A nurse will call you the day before your surgery/procedure with instructions and the time to arrive for check-in, based on the estimated time for your procedure. Procedure start times are dependent on many factors when there are patients on the schedule ahead of you. You may be asked to come in earlier or later than you anticipated, if cases cancel or go longer than scheduled.

For those patients who have an advance directive with a “Do Not Resuscitate” component, please be aware we do not honor that portion of advance directives during your stay, as it is our intent that all our patients will be going home as planned. If you wish to bring in your advance directive (living will), we will be happy to place a copy in your file for reference.

To prevent any loss or damage to your belongings, we advise that you ***do not bring unnecessary valuables to the surgery center***. This includes jewelry, wallets and handbags, cell phone, or laptops. Only bring with you this completed packet, insurance card, driver’s license or type of ID, a form of payment for any copay or deductible and your reading glasses to sign the surgical consent.

All patients receiving sedation of any sort are required to have a responsible adult for transport home, with an adult able to stay for 4-24 hours as required by the type of anesthesia.

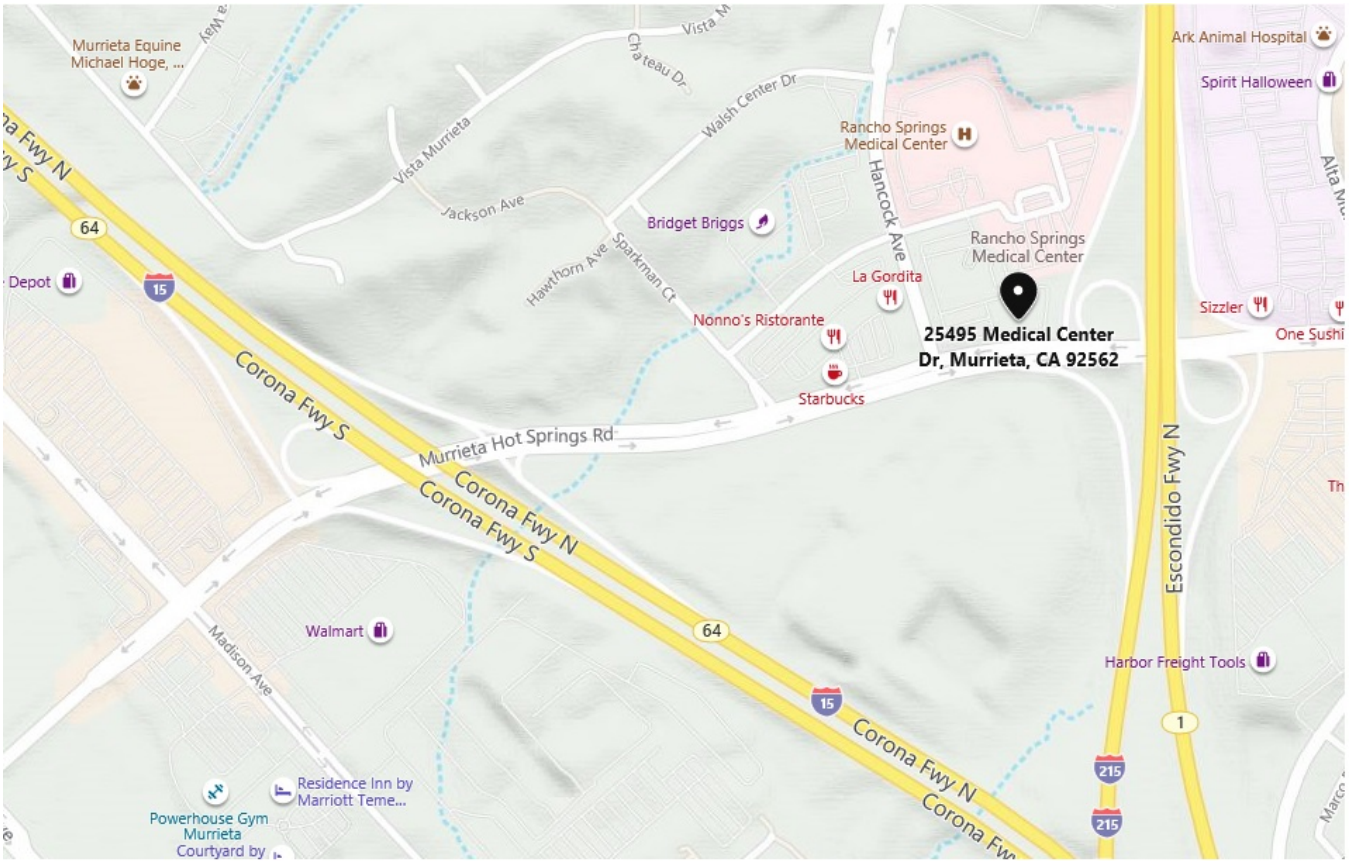
Designated drivers need to notify the front desk when leaving the building. Designated drivers need to be available in case of emergency.

If you have any comments or suggestions to help us improve our care, feel free to direct your comments to any staff member during your stay, or to our Administrator or our Medical Director, at the above phone number. We appreciatate your input.

Thank You!!

TEMECULA VALLEY
DAY SURGERY

25495 Medical Center Drive STE 101
Murrieta, CA 92562



Once on Medical Center Drive, turn right into the first driveway on the right and follow it back to the three story brown-glass building at the end of the driveway. We are on the first floor on the right once you're in the lobby located at the front of the building.

DIRECTIONS TO TEMECULA VALLEY DAY SURGERY:

25495 MEDICAL CENTER DRIVE

RANCHO SPRINGS MEDICAL PLAZA II, SUITE 101

MURRIETA, CA 92562

Traveling on I-5 north take the I-215 north - exit Murrieta Hot Springs turn left onto Murrieta Hot Sprins Road. Turn Right onto Hancock - 2nd light. Turn right onto Medical Center Drive - 1st light. Turn right into the first driveway on your right. Follow the street all the way to Rancho Springs Medical Plaza II (the three story brown building).

Traveling on I-5 south - exit Murrieta Hot Springs turn left onto Murrieta Hot Sprins Road. Turn left onto Hancock - 2nd light. Turn right onto Medical Center Drive - 1st light. Turn right into the first driveway on your right. Follow the street all the way to Rancho Springs Medical Plaza II (the three story brown building).

Traveling on I-215 south - exit Murrieta Hot Springs turn right onto Murrieta Hot Sprins Road. Turn right onto Hancock - 1st light. Turn right onto Medical Center Drive - 1st light. Turn right into the first driveway on your right. Follow the street all the way to Rancho Springs Medical Plaza II (the three story brown building).

Traveling on Murrieta Hot Springs going west- Turn right on Hancock - 1st light. Turn right onto Medical Center Drive - 1st light. Turn right into the first driveway on your right. Follow the street all the way to Rancho Springs Medical Plaza II (the three story brown building).

Traveling on Hancock going south - turn left onto Medical Center Drive before Murrieta Hot Springs Road. Turn right into the first driveway on your right. Follow the street all the way to Rancho Springs Medical Plaza II (the three story brown building).

If you have any questions, feel free to call (951) 200-7777

Temecula Valley Day Surgery

25495 Medical Center Drive STE 101, Murrieta, CA 92562

FINANCIAL POLICIES

We find that communication with our patients regarding our financial policies assists us in providing you with the best service possible and helps to eliminate misunderstandings.

- INSURANCE: As a courtesy to our patients, we will bill your primary, as well as your supplemental, insurance for services rendered. You must be aware that it is your responsibility to provide us with up to date insurance information and forms necessary for us to file your claims. You are, however, ultimately responsible for any and all costs incurred.

- SELF-PAY: If you do not have insurance coverage and you need to make payment arrangements, please notify us immediately. The initial office visit fee is due, in full, at the time of service. You should also be aware that certain procedures are due and payable in full prior to the procedure.

  If there is a balance left owing, a statement will be sent notifying you of the amount due. All balances are due and payable upon receipt of the statement. If the balance is not paid in full by the next billing cycle, a $10.00, per month, re-billing fee will be added. If the balance has not been paid within 60 days of the original billing date, we will be forced to pursue legal actions to collect any outstanding balance, and you will be responsible for the collection costs and any interest that has accrued at 12% per annum.

- HMO PATIENTS: its the sole responsibility of the patient to supply the office with a valid referral at the time of each visit. If you fail to obtain necessary referral and authorization you will be responsible for any and all services rendered. It is also ***extremely*** important that you notify this office if your medical group or insurance carrier changes. If payment is denied by your insurance, you are liable for the costs of all services rendered.

- **FACILITY CHARGES vs PHYSICIANS CHARGES:** Temecula Valley Day Surgery charges are separate and not included in the physician charges. This means you may receive two statements, one from the facility and one from the physician.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICIES.

X_____ _____

Patient / Responsible Party Signature **Date**

Temecula Valley Day Surgery

25495 Medical Center Drive STE 101, Murrieta, CA 92562

PATIENT INFORMATION

PLEASE FILL OUT ALL INFORMATION COMPLETELY

Name _____ Female _____ Male _____ Birth Date ____/____/____ Age _____
Last First Middle Month Day Year

ADDRESS _____ _____ _____ _____
Street No. or P.O. Box City State Zip

Home Phone (____) _____ Cell Phone (____) _____ SS # _____

Email _____ Drivers License # _____

Currently Employed? Yes ___ No ___ Marital Status? Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Patient/Responsible Party's Employer _____ Phone _____

Employer's Address _____ _____ _____ _____
Street No. or P.O. Box City State Zip

Emergency Contact _____ Relationship _____ Phone _____

Spouse's Name _____ Employer _____ Phone _____

INSURANCE INFORMATION

Primary Insurance Co. _____

Name of Policy Holder _____

SS # _____ DOB _____

ADDRESS _____
Street No. or P.O. Box

_____
City State Zip

Phone _____

Secondary Insurance Co. _____

Name of Policy Holder _____

SS # _____ DOB _____

ADDRESS _____
Street No. or P.O. Box

_____
City State Zip

Phone _____

WORKERS COMPENSATON INFORMATION

Name of WC Ins. Co _____ Contact Person _____

ADDRESS _____ Contact Person _____
Street No. or P.O. Box

_____ Claim/Case No _____
City State Zip

Verified By _____ Phone _____ Injury Date _____

Condition related to accident/ injury? Y ___ N ___ Date of Occurence _____ Attorney's Name (if any) _____

Consultation Requested By _____ Name of Primary Care Physician _____

TO ENSURE THE BEST QUALITY CARE, WE NEED THE NAME AND CONTACT NUMBER OF THE INDIVIDUAL TRANSPORTING YOU HOME

NAME: _____

PHONE NUMBER: _____

I certify that the above information is correct; I also understand that even though I have some type of insurance coverage, I am responsible for payment of services.

Signature of Patient or Responsible Person: _____ **Date** _____

Temecula Valley Day Surgery

25495 Medical Center Drive STE 101, Murrieta, CA 92562

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

The Healthy Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used.

As requires by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclosed your medical records only for each of the following purposes: Treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination, (history and physical), etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, utilization review. An example of this would be sending a bill for your visit to your insurance company for payment (and such follow-ups deemed necessary)
- Health care operations include the business aspects of running the "Center", such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, follow-up information about treatment or procedures, or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction, we must abide by it unless you agree in writing to remove it.
- The right to a reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____20___ and we are required to abide by these terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices form this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

TVDS Patient's Rights

The rights of patient(s) include, but are not limited to:

1. Exercise these rights and be free from any act of discrimination or reprisal, without regard to sex or cultural, economic, educational, or religious background or the source of payment for his/her care.
2. Considerate and respectful care. Free from all forms of abuse and harassment.
3. Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians who will see him/her.
4. Receive information from his/her physician about his/her illness, course of treatment, and prospects for recovery in terms that he/she can understand.
5. Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in each and to know the name of the person who will carry out the procedure or treatment.
6. Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.
7. Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual.
8. Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the center. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
9. Reasonable responses to any reasonable requests he/she may make for service.
10. Leave the center even against the advice of his/her physicians.
11. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
12. Be advised if center/personal physician proposed to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.
13. Be informed by his/her physician or a delegate of his/her physician of his/her continuing health care requirements following his/her discharge from the center.
14. Examine and receive an explanation of his/her bill regardless of source of payment.
15. Know which center rules and policies apply to his/her conduct as a patient.
16. Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
17. Designate visitors of his/her choosing. If the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless; (A) No visitors are allowed; (B) The facility reasonably determines that the presence of a particular visitor is detrimental to the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility; (C) the patient has indicated to the health facility staff that the patient no longer wants this person to visit.
18. Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the center policy on visitation. At a minimum, the center shall include any person living in the household.
19. This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.
20. Be advised of his/her right to change his/her provider if other qualified providers are available.
21. The right to be informed about the Center's policy on Advance Directives, including but not limited to 'Do Not Resuscitate'(DNR) directives.

Complaints can be addressed to the **TVDS Management / Administrator at 951.200.7777**

California Health and Human Services
1600 Ninth Street, Room 460
Sacramento, CA 95814
(916) 654-3454

Office of Medicare Beneficiary Ombudsman
www.medicare.gov/Ombudsman/activities.asp
1-800-MEDICARE

Accreditation Association for Ambulatory Healthcare
5250 Old Orchard Rd. Ste. 200 Skokie, IL 60077
(847)853-6060

TVDS PATIENT'S RESPONSIBILITIES

The responsibilities of the patient at this center are as follows:

1. To provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
2. Follow the treatment plan prescribed by his/her provider.
3. Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider. Inform his/her provider about any living will, medical power of attorney, or other advance directive that could affect his/her care.
4. Accept personal financial responsibility for any charges not covered by his/her insurance.
5. Be respectful of all the health care providers and staff, as well as other patients.
6. To follow preparation instructions and to call with any questions or problems.
7. To follow the physician's post-procedure instructions.

If a patient is found to be in non-compliance with the Patient Responsibilities set forth by the Center, or if the patient violates any rules or regulations set forth by the Center, the Center reserves the right to dismiss the patient from the premises and/or refuse treatment or services.

PATIENT GRIEVANCES NOTIFICATION

POLICY:
Occasionally, situations may arise that are difficult to resolve. Thus, the grievance process is available to patients who wish to have a problem formally reviewed.

The Grievance review will progress up to the center Administrator /Medical Director or his/her designee if necessary. The decision by the Medical Director or designee will be binding on all parties involved. The objective is to reach a decision that is mutually satisfactory to all parties involved.

PROCEDURE:

- A patient who wishes to utilize the Grievance procedure must do so in the prescribed manner.
- A patient may submit a problem orally or in writing to the Administrator / Medical Director within three (3) working days after the problem becomes known to the patient.
- The Administrator will attempt to resolve the patient's grievance during the initial meeting. If unable to reach a mutually agreed upon settlement, the Medical Director will investigate the situation further and will make a best effort, within thirty (30) working days, to send to the patient a written notification of the decision.
- The center will document how the grievance was addressed.
- The notification to the patient will contain the name of the center’s contact person, the steps taken to investigate the grievance, the results of the investigation and the date the investigation was finalized.
- If the patient isn’t satisfied then they may then file an external grievance with the U.S. Department of Health and Human Services.

GRIEVANCE PROCEDURE GUIDELINES

- Established center policy or procedure is not, itself, subject to the grievance procedure. It is only the interpretation or execution of these policies that can create a grievance.
- Every grievance should be submitted orally or in writing within three (3) working days after the problem becomes known to the patient.
- The grievance procedure is available to all patients and visitors of the center.
- A person may file an external grievance by filing a complaint of discrimination on the basis of handicap with the U.S. Department of Health & Human Services, Office for Civil Rights.

Please contact Temecula Valley Day Surgery Center with any questions: 951-200-7777

Temecula Valley Day Surgery

25495 Medical Center Drive STE 101, Murrieta, CA 92562

PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessment and physician certifications.

I have received, read and understand your N*otice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so documented below:

Reason:_____

Signature:_____ Date:_____

Temecula Valley Day Surgery

25495 Medical Center Drive STE 101, Murrieta, CA 92562

PATIENT'S SIGNATURE ON FILE

MEDICARE AND/OR OTHER HEALTH INSURANCE AUTHORIZATIONFOR PAYMENT

Patient Name: _____ **Date of Birth:** _____

Medicare/Health Insurance Number: _____

I request that payment of Medicare/Health Insurance benefits be paid on my behalf directly to: Temecula Valley Day Surgery, and/or Physician/Health care Provider.

These payments are for services provided to me at Temecula Valley Day Surgery and my Physician/ Health care Provider. I also authorize any holder of medical information about me to release such information to: The Health care Financing Administration and its agents, as needed to determine these benefits or the benefits payable for related services.

If item 9 of the HCFA-1500 claim for is completed, my signature authorizes the release of information to the insurer or agency shown. In Medicare assigned cases, Temecula Valley day Surgery and or the Physician/Health care Provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only deductible, co-insurance, and/or non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

_____ _____

Patient / Responsible Party Signature **Date**

NOTICE TO ALL PATIENTS

Temecula Valley Day Surgery is a facility dedicated to the patient healthcare. Our Physicians ***are not*** Primary Care Physicians, therefore, if you are having a medical problem other than what your physician is treating you for here at the “Center”, please see your Primary Care Physician. Also, please be aware the Facility does not function as an Emergency Room. In case of an emergency you should contact your Primary Care Physician.

_____ _____

Patient / Responsible Party Signature **Date**

TEMECULA VALLEY
DAY SURGERY

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services that you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one antipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between healthcare providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be represented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who selects a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Furthermore, both parties are spared some of the rigors of trial and publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please do not hesitate to ask us.

Thank you,

Temecula Valley Day Surgery

TEMECULA VALLEY
DAY SURGERY

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Thank you,

Temecula Valley Day Surgery

TEMECULA VALLEY DAY SURGERY CENTER

FACILITY-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Abitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbotration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation,or partnership, and the employees, agents and estates of any of them must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties, each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the arties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of expenses and fees or wirness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accorance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof if received, the claim, if asserted in civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within thirty days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

_____
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remin in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Authorized Reprentative's Signature (Date)

TEMECULA VALLEY DAY SURGERY CENTER
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____
Patient's or Patient's Representative's Signature (Date/Time)

By: _____
Print Patient Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

TEMECULA VALLEY
DAY SURGERY

MEDICATION RECONCILIATION LIST
HOME MEDICATIONS

☐ **List Attached**

ALLERGIES: _____

☐ **NO KNOWN DRUG ALLERGIES** ☐ **I deny taking any home medications**

LIST OF CURRENT MEDICATIONS

Include oxygen, supplements, vitamins, and any other medications

for physician use only

Medication	Dose	Route	How often	Reason	Dose	May resume / date

_____
Patient Signature

NURSE IS TO READ BACK & VERIFY MEDICATION(S) AS STATED

_____ _____ _____
RN Signature Date Time

Discharge Medication Information

☐ **No change to your current home medications. If you have any questions, please contact your doctor.**

☐ **NEW Medication:**

Medication Name	Strength	How to Take	How Often	Reason for Medication

I have reviewed this information with the patient / family

_____ _____ _____ _____
RN Signature Patient/Representative Signature Date Time

_____ _____ _____
Physician Signature Date Time

ID / Visit: /

DOB:

Phys:

DOS:

Sex:

Age:

TEMECULA VALLEY DAY SURGERY

Name: _____

Date of Birth: _____

PATIENT PRE-OPERATIVE QUESTIONAIRE

To be completed by the patient or their representative

General Information:	
Allergies: ☐ No known allergies to medication	☐ I have medication allergies, please list:

YES	NO	
☐	☐	I have had an unexpected problem during or after anesthesia or after surgery
☐	☐	I have had a family member who had an unexpected problem or died during anesthesia or surgery.
☐	☐	I have an Advance Directive. If I can't make my own decisions, my decision-maker is:
☐	☐	I have had blood transfusions
☐	☐	I will accept a blood transfusion or blood products
☐	☐	Take or treated with steroids, cortisone, prednisone
☐	☐	I wear contact lenses ☐ left eye ☐ right eye ☐ I have glaucoma
☐	☐	I have dentures, partial, bridge, caps, or loose teeth

List of Past Operations	Year	List of Past Hospitalizations	Year

YES	NO	DO YOU NOW OR HAVE YOU EVER HAD:
☐	☐	Cold, flu, or other infection within the past two (2) weeks
☐	☐	Is there any chance you could be pregnant
☐	☐	Lung Disease (TB, bronchitis, asthma, emphysema, chronic cough)
☐	☐	Smoke, if YES how many packs per day?
☐	☐	Short of breath ☐ at rest or sleeping ☐ walking/exercising
☐	☐	Sleep apnea ☐ Sleep with head up on pillows or in a chair ☐ Use CPAP machine
☐	☐	Heart Disease (heart attack, heart murmur, rheumatic fever, heart failure) ☐ High BP ☐ Low BP
☐	☐	Irregular heart beat (atrial fibrillation, fast or slow heart rate)
☐	☐	Bleeding disorder or on blood thinners
☐	☐	Hepatitis, jaundice (yellow eyes/skin) or other liver problems
☐	☐	Neurological Problem: ☐ Paralysis or stroke, if YES date: ☐ Epilepsy, Seizure, Fainting Spells
☐	☐	Kidney disease, infections, or nephritis ☐ I am on dialysis
☐	☐	GI Problems such as: ☐ Heart burn ☐ Hiatal hernia ☐ Stomach Ulcers ☐ Irritable Bowel
☐	☐	Immune disease (such as Lupus, porphyria), muscle or nerve disease
☐	☐	Endocrine Problem such as: ☐ Diabetes ☐ Low Blood Sugar ☐ Thyroid
☐	☐	Back problems, herniated disc
☐	☐	History of excessive alcohol, drug, or medication use/abuse
☐	☐	History of infection ☐ MRSA ☐ HIV

Additional information I want you to know about me . . .

Completed by:	Print Name:	Signature:	Date:

If completed by someone other than the patient, please indicate your relationship: