Nacogdoches Surgery Center

Dear patient,

In an effort to make checking in with our facility easier we are providing this packet of information we will need from you.

Please read, fill in, sign, date and time each page where indicated and bring with you on the date of your procedure.

If you have any questions or need help please feel free to reach out to us at (936) 560-9599.

With COVID restrictions:

- masks are required while in the lobby
- only 1 person may wait in the lobby while you are in your procedure.

Thank you,

Nacogdoches Surgery Center Staff

3610 N University Drive
Nacogdoches, TX 75965

Phone# 936-560-9599
Fax# 936-560-6933

GRASSHOPPER
ANESTHESIA SERVICES PLLC

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

ASSIGNMENT OF INSURANCE BENEFITS. In consideration of services rendered, I hereby assign and transfer to **GRASSHOPPER ANESTHESIA SERVICES PLLC.**, 4865 CR 260, Nacogdoches, Texas 75965, referred to as "GAS," for myself and my dependents all rights, title and interest in the benefits payable for services, treatments and medications rendered or provided by GAS, or its CRNAs, Anesthesiologists, Physicians, or ancillary providers, its providers in any insurance policy(ies) under which I or any of my dependents are insured. This irrevocable assignment and transfer of benefits shall be for the purpose of granting GAS an independent right of recovery in any policy(ies) of insurance, to which benefits may be payable for the anesthesia services, treatments or medications I receive, but shall not be construed to be an obligation of GAS to pursue any such rights or recovery. Each person signing the Admission Agreement is financially responsible for charges not collected by this assignment to Associates within thirty (30) days.

I also assign to GAS for the medical services, treatments and medications I receive all rights, title and interest in benefits payable out of any third party action against any other person, entity or insurance company, or out of recovery under the uninsured motorist provisions of the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover.

I also authorize my plan administrator, fiduciary, insurer and/or attorney to release to GAS and other Physician, Anesthetist, Radiologist, Lab and any other independent practitioners any and all plan documents, summary plan description, insurance policy and/or settlement information upon written request from GAS and any other Physician, Anesthetist, Radiologist, Lab and independent practitioners or its attorneys in order to claim such medical benefits for the medical services I receive.

I also assign and/or convey to GAS and any other Physician, Anesthetist, Radiologist, Lab and independent practitioners any legal or administrative claim arising under any group health plan, employee benefits plan, individual health insurance plan concerning medical expenses incurred as a result of the services, treatments or medications I receive from GAS (including any right to pursue those legal or administrative claims.) This constitutes an express and knowing assignment of ERISA breach of fiduciary claims and other legal and/or administrative claims.

GAS and any other Physician, Anesthetist, Radiologist, Lab and independent practitioners as my assigned and designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at their expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, Medicaid and applicable federal and state laws.

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered. I agree to pay GAS any and all charges not paid for by insurance. Copayments or deductibles are due, in full, at the time of service.

I agree to cooperate, aid and assist GAS in procuring all possible insurance benefits. I understand that it is my responsibility to comply with referral and pre-certification as may be required by my insurance company.

AUTHORIZATION FOR RELEASE OF INFORMATION. I certify that the information given in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to GAS and authorize GAS to submit claims to Medicare for payment. I understand that I am responsible for any health insurance deductibles and co-insurance.

AUTHORIZATION FOR COMMUNICATION. I grant permission for GAS to leave confidential and/or surgical information on my answering machine, voicemail or cell phone. GAS will use all means of communication, including but not limited to email and texting, unless otherwise specified.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. GAS will not release any information other than under those circumstances described above, unless disclosure is required by law, a court, a legal process or governmental

agencies. Any concerns you may have pertaining to the security of your information should be directed to this office. I understand that HIPAA policies are available for review upon request.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature _____ Date _____

Patient Name (Printed) _____ Date of Birth _____

Date of Service _____

I approve the following person and/or family members to receive medical information and copies of my medical records.

_____

_____

Signature of Representative _____ Relationship _____ Date _____

Printed Name of Representative _____

Nacogdoches Surgery Center

Anesthesia Evaluation Report

Patient Label here

Age:		BP		O2 Sat	
Height:		Pulse		Temp	
Weight:		Resp			

HAVE YOU HAD:	Yes	No
Heart Trouble/Chest pains		
High Blood Pressure		
Lung Disease/Difficulty Breathing/Productive Cough		
Asthma / Bronchitis		
Sleep Apnea		
GERD/Heart burn		
TB or Had any exposure to TB in the last 3 months		
Hepatitis or Jaundice		
Thyroid Issues		
Back Trouble		
Glaucoma		
Abnormal Bleeding Tendencies		
Anticoagulant Therapy (blood thinners)		
Blood Disease (anemia, etc.)		
Kidney Disease/Difficulty with Urination		
Fracture of Facial Bones		
Fracture of Neck or Back		
Muscle Weakness		
Paralysis/Numbness/Tingling		
Blood Transfusion		
Stroke		
Blood Vessel Disease (phlebitis, etc)		
Diabetes FBS this AM		
Arthritis		
Chest X-ray in past year		
Electrocardiogram in past year		

Do You: (√ if brought to center)		√	Yes	No
Wear Dentures				
Have Loose Teeth/Caps/Bridges				
Wear Glasses/Contacts				
Wear Prosthesis				
Wear Hearing Aid				
Do You Smoke?	Pks/Day	Since age		
Date Quit Smoking				
Use Alcohol? (Amt/Day)				
Females: Could You Be Pregnant?				
Religious Objection to Blood Transfusion?				

Drug Allergies and Description of Reaction

Previous Surgeries and Dates

Abnormal Reactions to Surgeries or Anesthetics

Medications, including Non Prescription Supplements

When did you last eat or drink?

Comments:

Patient Signature: **Date:** **Time:**

Immediate Pre-Anesthesia Evaluation

☐ Gen/TIVA ☐ Block ☐ MAC ☐ Other

☐ The Patient is stable medically and is a good candidate for surgery and Anesthesia.

☐ Risks, options, benefits to Anesthetic plan discussed with patient/parent/guardian. Responsible party appears to understand, agrees, and gives consent.

ASA Status: 1 2 3 4 E

Anesthetists _____ Date/Time _____

Post-Anesthesia Discharge Evaluation

Recovery Satisfactory:	☐ Yes	☐ No
Vital Signs Satisfactory	☐ Yes	☐ No
Mental Status Satisfactory	☐ Yes	☐ No
Temperature Satisfactory	☐ Yes	☐ No
Pain Level Satisfactory	☐ Yes	☐ No
Nausa Level Satisfactory	☐ Yes	☐ No
Hydration level Satisfactory	☐ Yes	☐ No

Comments:

Anesthetists _____ Date/Time _____

CENTER: Nacogdoches Surgery Center

Patient Label

Patient's Bill of Rights and Responsibilities

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

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

III. A patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly.

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

V. A patient has the right to know what Ambulatory Surgery Center rules and regulations apply to his conduct as a patient.

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

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

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

IX. Except for emergencies, the practitioner shall obtain the necessary informed consent prior to the start of a procedure. Informed consent is defined in Texas Administrative Code, Title 25, Part 7, Chapter 601.

X. A patient or, if the patient is unable to give informed consent, a responsible person, has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program, and the patient, or responsible person, shall give informed consent prior to actual participation in the program. A patient, or responsible person, may refuse to continue in a program to which he has previously given consent.

XI. A patient has the right to refuse drugs or procedures, to the extent permitted by statute, and a practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.

XII. A patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sexual orientation, national origin, handicap, disability or source of payment.

XIII. The patient who does not speak English shall have access, where possible, to an interpreter.

CENTER: Nacogdoches Surgery Center **Patient Label**

XIIII. The Ambulatory Surgery Center shall provide the patient, or patient designee, upon request, access to the information contained in his medical records, unless access is specifically restricted by the attending practitioner for medical reasons.

XV. The patient has the right to expect good management techniques to be implemented with the Ambulatory Surgery Center. Those techniques shall make effective use of the time of the patient and avoid the personal discomfort of the patient.

XVI. When an emergency occurs and a patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.

XVII. The patient has the right to expect that the Ambulatory Surgery Center will provide information for continuing health care requirements following discharge and the means for meeting them.

XVIII. A patient has the right to be informed of his rights at the time of admission.

XIX. The Ambulatory Surgery Center expects the patient to ask questions about any directions or procedures they don't understand.

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

XXI. The patient is expected to follow instructions and medical orders and report unexpected changes in their condition to their physician and center staff.

XXII. The patient is expected to follow all safety regulations that they are told or read about.

XXIII. If the patient fails to follow their healthcare provider's instructions, or if the patient refuses care, they are responsible for their own actions. The patient can choose to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

XXIV. The patient has the right to know if their physician has an financial interest or ownership in the A.S.C.

The physicians, nurses and the entire staff at Surgery Center are committed to assure you reasonable care. Should you have a complaint or grievance related to the Nacogdoches Surgery Center, contact the Administrator at 936-560-9599.

If your complaint or grievance is not resolved to your satisfaction, you may contact The Director of Health Facility Licensure and Certification, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756, (888) 973-0022. Presentation of a complaint will not compromise your care under any circumstances.

Patient's Signature	Date	Time
Witness Signature	Date	Time

Nacogdoches Surgery Center

Consent to Medical Care: I

Consent for Admission and Treatment

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

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

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

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

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

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

Advance Directives:

I (we) acknowledge the following statement in regards to Advanced Directives: During the care at Nacogdoches Surgery Center, if an adverse event occurs, based on reasons of conscience, all reasonable efforts will be taken to revive the patient, including resuscitative or other stabilizing measures, regardless of the contents of any advance directive/living will/health care proxy or instructions from a healthcare agent. If you have any questions please talk to your physician or anesthesiologist.

☐ Do ☐ Do Not have an Advanced Directive. ☐ Copy given to NSC

Patient Rights: I acknowledge verbal and written notification of my rights as a patient prior to my procedure, and on request, I received a copy of the State notice and this facility policy statement regarding Patient's Right to Self-Determination.

Pre-operative Instructions: I acknowledge notification that pre-operative instructions for my procedure have been given to me by my physician and/or Nacogdoches Surgery Center, and that I have followed those instructions.

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

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

I have been informed that this facility may use reprocessed instruments.

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

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

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

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

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

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

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

Acknowledgement of Notice of Privacy Practices: A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in your admissions packet and posted in the Facility. By signing below you acknowledge that you have received a copy of the Facility's Notice of Privacy Practice.

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

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

Name/phone number _____

Name/phone number _____

Responsible Adult Driver Name / phone number (if different than above)_____

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

PATIENT SIGNATURE: **X** _____ Date:_____ Time:_____

WITNESS: **X** _____ Date:_____ Time:_____

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

Relative / Authorized Agent _____

Relationship to Patient: _____ Date:_____ Time:_____

Revised: May 2018

Nacogdoches Surgery Center

3610 N University DR

Nacogdoches, TX 75965

We here at the **Nacogdoches Surgery Center** want to welcome you here to our center and hope that we are able to meet all your needs in regards to your surgery. In an effort to ensure that you as a patient have been notified of some pertinent information concerning your rights as a patient. Please sign below indicating you were presented with the following information by your physician prior to your surgery.

Our Patient Bill of Rights

A List of Physician partner and investors

The centers policy on Advanced Directives

The Texas Health and Safety Code on Advance Directives

The centers patient financial policy

This information is also listed here in your chart on various consents and will be a part of your permanent records. If you have any questions about your rights or anything that has been presented to you, please do not hesitate to ask any of our staff.

_____ _____ _____

Patient Signature Date Time

Center physician owners: Clifton Thomas, MD, Eduardo Tanhui, MD, Michael McLean MD, Edwin Ferren, MD, Larry Laurich, DPM, Gregory Wittpenn, MD, Mark Sowell, DPM, Gregory Tate, MD and Carl Jones, DO