FRONT RANGE
SURGERY CENTER

Hello! Thank you for choosing Front Range Orthopedic Surgery Center for your needs.

Enclosed are some of our operative forms. Please complete the forms and return them to our office about a week to 10 days before your procedure. Our office is at 1610 Dry Creek Drive, Suite 100, in Longmont. Or you may fax them to us at 720-494-3209. Please do not return forms through email.

The following are form specific directions:

- **List of Medications:**
  - This is for *anything* you take on a daily basis for general health or illness. Include all herbal supplements and vitamins. If you have medication allergies or adverse reactions, please list those on the third line. Do not go below the arrows.
- **Pre-operative & Pre-anesthetic Assessment:**
  - This is a basic health history form used by the anesthesiologist. Each box should have a yes or no filled in. Please do not draw lines all the way down, as each condition needs to be addressed. An explanation of health issues for all "Yes" answers may be written in the blank column next to the appropriate box. ***Please do not write in the bottom section below the dark line.*** This portion is for the doctor on the day of surgery. Sign and date this form right above the dark line.
- **Anesthesia Consent:**
  - ***Do not sign this form without a witness from our office.*** Please review all the information regarding different anesthesia in use in our facility. You will have an opportunity to speak to one of our anesthesiologists *before* your surgery to have any questions answered.
- **Authorization to Release Information:**
  - This informs us of whom you would like us to be able to share information with. Any family members or friends must be on this list for us to speak to them about your care. We will not release any of your information to anyone unless they are listed here. (Please see our HIPPA forms.)
- **Summary Notices of Privacy Practices:**
  - Our longer form is within this packet of information. Please review it and sign the summary form to return to us.
- **Patient Rights and Responsibilities:**
  - Review this information, including the notice regarding Advance Directives and Grievance policies. Please make sure to check the appropriate line if you have an Advance Directive and *bring a copy with you on the day of your surgery.*

You will receive a call from a preoperative nurse approximately one week before your scheduled procedure. It is important that you speak to this nurse. Please be sure we have an accurate phone number and that, if they leave you a message, to return their call promptly. The nurse will get your health history to determine if any preoperative lab work is needed. The nurse also has some important preoperative instructions to give you regarding expectations about your surgery and home care afterwards.

You will receive a satisfaction survey in the clinic on your first postoperative visit. Please tell us how we are doing by completing this survey and returning it to one of the clinic staff on your way out of the office. Thank you again for choosing our facility.

Medication Reconciliation Form

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Patient Name _____ **Date** _____ **Time** _____
Pharmacy Name _____ **Pharmacy Phone Number or Address** _____
Allergies _____

Please list all medication you are currently taking, *including any medications you are holding because of surgery, any over the counter medications and any herbal remedies.* *DO NOT* complete the shaded area on the right until the day of surgery. The instructions on when to resume medications will be completed on the day of surgery.

Medication	Dosage	Frequency	Last Taken	Resume at Next Scheduled Time	Resume Tomorrow	Hold until Post-Op Appt
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

_____ _____ _____
Patient Signature **Date** **Reviewing RN on Day of Surgery**

For Post Operative Use

After surgery, you may need the following over-the-counter medications:

- **For blood clot prevention:**
  - ☐ **Aspirin—use 81 mg / 325 mg dosage, 1 or 2 times per day, stopping on _____.**
  - ☐ **Other medication (see below)—_____, stopping on _____.**
- **For pain relief:**
  - ☐ **You may use a non-steroidal anti-inflammatory (NSAID) such as Ibuprofen (Motrin/Advil) or Naproxen (Aleve) as needed. Your surgeon recommends ONE of these dosages: Ibuprofen 400mg every 4 hrs, Ibuprofen 600 mg every 6 hrs, Ibuprofen 800mg every 8 hrs, or Naproxen 220mg every 12 hrs.**
  - ☐ **STOP all NSAID use after 5 days post-op as it may inhibit bone growth.**
  - ☐ **DO NOT use any NSAID medications until your follow-up appointment.**
- **For constipation:**
  - ☐ **Over-the-counter stool softener such as Docusate (Colace) 100mg twice per day.**

New prescriptions given today:

Medications	Dosage	Directions/Frequency	eason for taking	rdering Physician

If you receive a prescription for a "controlled" (Schedule II through V) drug, your identifying prescription information will be entered into Colorado's Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you. Your prescription information in the database is a protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

_____ _____ _____
Discharge RN Signature Patient/Caregiver Signature MD/PA Signature Date/Time

Note to patient: Please take this medication list to your next doctor's appointment. It is recommended that you bring a list of your current medications to every medical appointment.

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Patient Identification

PRE-OPERATIVE & PRE-ANESTHETIC ASSESSMENT

HAVE YOU HAD OR STILL HAVE	YES	NO
A cold, presently		
Sleep apnea		
Use of home oxygen		
Emphysema		
Asthma		
Other lung disease, e.g. TB		
Do you or have you smoked?		
Packs per day?		XXX
Heart attack, When?		
Chest pain, angina		
Irregular or skipped beats		
Heart murmur		
High blood pressure		
Heart failure		
Heart catheterization		
Angioplasty, bypass surgery		
Circulation problems		
History of blood clots		
Anemia or sickle cell disease		
Jaundice, hepatitis		
Liver disease		
Alcoholic beverages, daily		
Thyroid problems		
Kidney or bladder disorder		
Diabetes		
Gastric reflux/GERD		
Hiatal hernia		
Colon problems		
Arthritis		
Back or disc problems		
Migraine headaches		
Seizures / epilepsy		
Stroke / paralysis		
Numbness or tingling		
Other neurologic problems		
Frequent black-out episodes		
Ever addicted to drugs?		
Recreational use of drugs?		
Diagnosed with cancer		
Could you be pregnant?		
Last menstrual period		
Do you get motion sick		
History of nausea or vomiting		
with pain medicines		
after surgery		

Pediatric patients. Premature			
Peds. Immunizations up to date			
HAVE YOU HAD OR STILL HAVE	**YES**	**NO**	
Chest x-ray in last year			
EKG in last 6 months			
Lab work in last 2 weeks			
Partials or dentures			
Capped or loose teeth			
Body jewelry			
Anesthesia problems yourself or family			
Do you have an Advanced Directive?			
Latex sensitivity / Allergy			

Other illness:

Previous Surgeries: **When?**

Current Medications Including Herbal, Over the Counter, Supplements:
See List of Medications

Allergies to Medications: **Type of Reaction:**

Do not fill in any information below - Doctor use only

Signature of Patient **Date**

Age: _____ M / F NPO: _____

Mental Status: Normal___ Altered___

Airway: I II III IV

Lungs:

Heart:

ASA: I II III IV

Plan: GA MAC GA/MAC Regional:_____

Post-Op Pain Mgmt. Block: Supraclavicular ISB AXB FEM Adductor canal Popliteal

Anesthesia management & risks explained to patient/guardian.
Consent to proceed. ❑

Surgery site verified by patient: L R BIL NA

EKG:

H/H:_____ FBS:_____ K+:_____

Comments:

Anesthesiologist Signature Date

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ANESTHESIA CONSENT

Anesthesia is a specialty medical service that administers anesthetic agents to patients and manages patients who are rendered unconscious or have diminished response to pain and stress during the course of a medical, surgical, or obstetrical procedure.

A. General Anesthesia
1. Technique: Medicines injected into the bloodstream and breathed into the lungs after unconsciousness.
2. Expected Result: Total unconsciousness during surgery.
3. Specific Risks: Breathing stomach contents into the lungs, pneumonia, nausea and vomiting, mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, nerve injury, and malignant hyperthermia.

B. Spinal or Epidural Anesthesia
1. Technique: Medicines injected through a needle or tube placed between the bones of the back, into the area around or in the spinal canal.
2. Expected Result: Temporary loss of feeling and/or movement to the lower part of the body or to the chest and belly.
3. Specific Risks: Seizures, headache, backache, nausea and vomiting, nerve injury-permanent weakness, numbness, or pain.

C. Peripheral Nerve Block
1. Technique: Numbing medicines injected through a needle or tube place near nerves of a limb, part of a limb, chest wall, or belly.
2. Expected Result: Temporary loss of feeling and movement of a limb or part of a limb, chest wall, or belly.
3. Specific Risks: Seizures, injury to blood vessel, nerve injury -permanent weakness, numbness, and pain or lung collapse.

D. Intravenous Regional Anesthesia
1. Technique: Numbing medicine injected into a vein of an arm while using a tourniquet.
2. Expected Result: Loss of feeling and movement of arm during surgery.
3. Specific Risks: Convulsions, nerve injury, injury to blood vessels.

E. Monitored Anesthesia Care (MAC)
1. Technique: Medicines injected into the bloodstream, producing a semi-conscious or unconscious state.
2. Expected Result: Reduced anxiety and pain, partial or total unconsciousness, possible amnesia.
3. Specific Risks: Slowed breathing, nausea and vomiting, injury to blood vessels.

The details of the procedure have been explained to me in terms I understand.
Alternative methods and their benefits and disadvantages have been explained to me.
I understand and accept that the most likely risks and complications for the anesthetic.

I will receive:

- ☐ **General Anesthesia**
- ☐ **Spinal or Epidural Anesthesia**
- ☐ **Peripheral Nerve Block**
- ☐ **Intravenous Regional Anesthesia**
- ☐ **Monitored Anesthesia Care (MAC)**

I understand that accidental dental injury is also a risk of anesthesia. The anesthesiologist cannot be held responsible for injuring teeth, partials, or dentures that are already damaged or in poor condition.

I understand and accept that there are complications, including the remote risk of death or serious disability, which exists with any anesthesia procedure.

I am aware that smoking during the pre and postoperative periods could increase chances of complications.

I have informed the doctor of all my known allergies. I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

I am aware and accept that no guarantees about the results of the procedure have been made.

The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this procedure agreement and that all blanks were filled in prior to my signature.

Patient or Legal Representative Signature _____ Date and Time _____

Relationship to Patient _____

Print Patient or Legal Representative Name _____

Witness Signature _____ Date and Time _____

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative fully understands what I have explained.

Physician Signature _____ Date and Time _____

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Authorization to Release Information

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to individuals you must sign this form. Signing this form will only give consent to release this information to the following individuals indicated below. This consent form will not allow Front Range Orthopedic Surgery Center to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow Front Range Orthopedic Surgery Center to release my medical and/or billing information to the following individual(s):

1._____Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Patient Printed Name:_____

Patient Signature:_____Date_____

Authorization to Leave Messages with Household Members, Answering Machine, or Personal Voicemail

Occasionally it is necessary for the staff of Front Range Orthopedic Surgery Center to leave messages for patients. The purpose of these messages is to obtain information regarding a scheduled procedure. At no time will a representative of Front Range Orthopedic Surgery Center discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient
Name:_____

Patient Signature:_____Date_____

FRONT RANGE SURGERY CENTER

Summary Notices of Privacy Practices

Dear Front Range Orthopedic Surgery Center Patient,

This Privacy Notice is being provided to you as a *requirement of a federal law*, the Health Insurance Portability and Accountability Act (HIPAA). It is the policy of Front Range Orthopedic Surgery Center to comply with the federal regulations regarding HIPAA. We strongly believe in protecting the confidentiality and security of your health information.

1. **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 notice is provided in two sections. This page briefly summarizes how we handle your health information, and the section found in your packet provides further details of our privacy policies and procedures.
2. **How we may use and disclose your health information**. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign and authorization to disclose information, you can later revoke it to stop any future uses and disclosures.
3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.
4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change to our policies, we will change our notice and post the new notice in our waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.
5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, please contact Vicky Burrack at 720-494-3200. You may also send a written complaint to the U.S. Department of Health and Human Services. FROSC can provide you with the appropriate address upon request. You may also file a complaint with our accrediting association, AAAHC at 847-853-6060 or Report Medicare Fraud & Abuse at 800-HHS-TIPS (1-800-447-8477).

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received both sections of this Notice of Privacy Practices. Then return this acknowledgement of receipt to the receptionist.

Signature:_____

Printed Name:_____ Date:_____

FRONT RANGE
SURGERY CENTER

1610 Dry Creek Drive, Suite 100, Longmont CO 80503
(720)494-3200 Fax (720)494-3209

PATIENT RIGHTS & RESPONSIBILITIES

As a patient of Front Range Orthopedic Surgery Center you have the following rights and responsibilities:

- The *right* to receive quality care and safe treatment given in a respectful and considerate manner.
- The *right* to receive care that is free of abuse, harassment or acts of discrimination or reprisal.
- The *right* to privacy regarding your medical care in case discussion, consultation, examination and treatment.
- The *responsibility* to be considerate of other patients and staff and to respect their rights to privacy and property.
- The *right* to receive all information necessary from your physician to give informed consent prior to the start of any procedure and/or treatment and the *responsibility* to ask questions if you do not understand any aspect of your care and treatment.
- The *right* to participate with your physician in making decisions involving your health care and the *right* to choose a surrogate decision maker in the event one is needed.
- The *right* to know the names, professional status and experience of the personnel providing care and the *responsibility* to be considerate and respectful of those who are caring for you.
- The *right* to know whether the facility is involved in any teaching, research or experimental programs.
- The *right* to refuse any drugs, tests, procedures or treatments, and to be informed of the medical consequences of your decision.
- The *right* to be informed of the surgery center's rules and regulations as they pertain to your admission.
- The *right* to receive an estimate of the charges for services based on your admitting diagnosis, and an estimate of any co-payments or other charges that may not be covered by your carrier, based on the insurance information you have provided.
- The *right* to view your medical record within the guidelines established by law (Only those individuals who are involved in your care or are authorized by law have access to your medical record. Anyone else wishing to view your medical record must obtain written consent from you).
- The *right* to change physicians if other qualified physicians are available.
- The *responsibility* to provide accurate, honest and complete information about your medical history that will help us care for you, including information about medications and drugs include over-the counter products, recreational drug use and dietary supplements, and any allergies or sensitivities you have used, previous illnesses, injuries or medical care you have received, and information about your current health status.
- The *responsibility* to follow your health care provider's instructions, take medications as prescribed and ask questions concerning your health care, if necessary, once you have agreed to the recommended care.
- The *right* to express complaints and concerns about your care without fear of recrimination.
- The rights to have a representative/surrogate file a grievance, formal or informal, written or verbal complaint on the patient's behalf. These can be regarding abuse, neglect or ASC compliance issues.

Formal grievances can be filed by contacting the Clinical Director at (720) 494-3201 or completing a grievance form which can be obtained from the receptionist.

You may also file a complaint with our accrediting association, AAAHC at 847-853-6060 or the Colorado Department of Health and Environment: by email to: hfdintake@cdphe.state.co.us, In the "Subject Line", enter: *ASC* Complaint Intake; by phone @ 303-692-2827 or 1-800-886-7689, ext. 2827, by fax @ 303-753-6214 or by mail to CDPHE, HFEMSD-A2, Attention: *ASC* Complaint Intake, 4300 Cherry Creek Drive South, Denver, CO 80246-1530. Medicare beneficiaries may contact the Medicare beneficiary Ombudsman @ http://www.medicare.gov/ombudsman/resources.asp.

PHYSICIAN OWNED FACILITY

I understand that the physicians on staff at Front Range Orthopedic Surgery Center providing medical services are in fact the owners of the facility.

ADVANCED DIRECTIVES

I consent to all resuscitative measures as deemed necessary by my physicians in the event of a life threatening emergency. Front Range Orthopedic Surgery Center feels that patients are in reasonably good health and of low surgical risk making resuscitation appropriate for conditions of preserving life, until transfer to a hospital occurs. I consent to emergency transfer to another facility (Longmont United Hospital or Exempla) in case of the need for emergency hospital care. The admitting facility is not affiliated or in partnership with Front Range Orthopedic Surgery Center.

Do you have an Advance Directive: ___Yes ___No

If you have any questions regarding any information here please call (720) 494-3200.
I have reviewed and understand the Patient Bill of Rights.

_____ _____

Signature of Patient or Responsible Party Date Time