Coastal Cosmetic Center

Medication Reconciliation

Patients Pharmacy: _____ **Pharmacy Phone #:** _____

*Do you consent for us to pull your medication history from all outside providers for your safety? **Yes** **No**

List ALL medications (prescribed, over-the-counter weight loss, vitamins, and supplements):

Medication Name	**Dosage**	**Treated Condition**	*Please mark 'X' for time taken.*			
			Morning	**Noon**	**Supper**	**Bedtime**

(attach patient sticker here)

Patient Signature: _____

Date: _____

Patient Name (Print): _____ **Date of Birth:** _____

Do you presently or have you ever experienced the following?

YES	**NO**	Abnormal bleeding	**YES**	**NO**	MRSA	**YES**	**NO**	Stomach ulcers
YES	**NO**	Heart murmur	**YES**	**NO**	Heart disease	**YES**	**NO**	Chest pain
YES	**NO**	Heart Attack	**YES**	**NO**	Heart Stents	**YES**	**NO**	Other stents
YES	**NO**	Artificial heart valves	**YES**	**NO**	High blood pressure	**YES**	**NO**	Glaucoma
YES	**NO**	Asthma	**YES**	**NO**	Abnormal clotting	**YES**	**NO**	Cancer
YES	**NO**	Post-op nausea/vomiting	**YES**	**NO**	Previous surgical infection	**YES**	**NO**	Chemo/Radiation
YES	**NO**	Diabetes	**YES**	**NO**	Pacemaker/ICD	**YES**	**NO**	HIV
YES	**NO**	COPD/Emphysema	**YES**	**NO**	Seizures	**YES**	**NO**	Hepatitis B or C
YES	**NO**	Excessive sweating	**YES**	**NO**	Sinusitis	**YES**	**NO**	Stroke
YES	**NO**	Fever blisters	**YES**	**NO**	Skin condition	**YES**	**NO**	Migraines
YES	**NO**	Sleep apnea	**YES**	**NO**	Neck injury/surgery	**YES**	**NO**	Depression/Anxiety

Please explain any above selection: _____

_____

Please list any other **medical** issues or conditions current or previous: _____

_____

Female Patients:

Are you /could you be pregnant? **Yes** **No**

# of pregnancies? _____ # of children? _____ # of breastfed children? _____

Approximate date of last mammogram? _____ ____ Normal? ____ Abnormal?

Please list ALL previous surgeries you have had including cosmetic surgeries or procedures:

Surgery	**MM/YY**	**Physician**	**Surgery**	**MM/YY**	**Physician**

Post-Op Nausea/Vomiting in the past? _____**Yes** _____ **NO**

Patient Name (Print): _____ Date of Birth: _____

Allergies/Reactions:

Yes **No** Aspirin	**Yes** **No** Erythromycin	**Yes** **No** Penicillin
Yes **No** Codeine	**Yes** **No** Iodine	**Yes** **No** Sulfa
Yes **No** Demerol	**Yes** **No** Morphine	**Yes** **No** Tetracycline

Reaction(s): _____

List additional drugs/items that cause allergic reactions (including tape, latex, jewelry, food, etc.)

_____

Health Habits:

Consumption of the following?

Aspirin	YES	NO	Amount Daily? _____
Alcohol	YES	NO	Amount Daily? _____
Tobacco	YES	NO	Amount Daily? _____
Have you smoked in the past?	YES	NO	# of years smoked? _____
Recreational drugs	YES	NO	Amount Daily? _____

It is mandatory and medically necessary for patients who smoke to **QUIT A MINIMUM OF TWO WEEKS PRIOR TO SURGICAL PROCEDURES AND A MINIMUM OF TWO WEEKS AFTER THOSE PROCEDURES, PLEASE DISCUSS WITH SURGEON IF YOU CANNOT REFRAIN FROM SMOKING.**

_____ **YES,** I can refrain from smoking _____ **NO,** I cannot refrain from smoking.

Family History:

Breast Cancer: _____ **YES** _____**NO** Relationship: _____

Skin Cancer: ____ **YES** ____ **NO** Relationship: _____

Bleeding Disorders: _____ **YES** ____ **NO** Relationship/Specify: _____

Other pertinent family history: _____

I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status.

Patient/Guardian Signature: _____ **Date:** _____

Print Name: _____

Coastal Cosmetic Center

Photographs

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

For several reasons, Timothy E. Fee, M.D., is often asked to show before and after photos of patients. Many patients give their permission to use their photos anonymously. We now ask that you do so as well.

Consent for use of Before & After Photos

I understand pre- and post- treatment pictures will be obtained for medical records. **Initial: _____**

I hereby authorize Coastal Cosmetic Center to use my photos in their before and after presentation to other patients interested in the same procedures including but not limited to showing these images in-office, print, internet, social media, and electronic digital networks. I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all representations, including patient discretion by removing any identifying marks / features to maintain anonymity.

Signature of Consent: _____ Date: _____

Refused: _____ Date: _____

Anesthesia Communication Preference:

Each patient has the opportunity to talk and meet with the anesthesia provider in the pre-operative area **on the day of surgery**. On the day of surgery, the anesthesia provider will review your health history, review medications, perform a brief physical examination, and review the plan of care for your surgery.

Occasionally patients have additional questions or concerns regarding anesthesia, their health history, or their medications that they would like to address before the day of surgery.

If you feel that you would like to speak with the anesthesia provider **BEFORE THE DAY OF SURGERY**, please indicate below (select only one):

_____ I do not need to talk with them in advance.

_____ I would like a phone call in advance.

_____ I would like an email in advance.

* Please be aware that if you have selected a phone call or email contact method, the provider may leave a voicemail, or the call/email may be flagged as SPAM or JUNK. *

Patient Initials: _____

Date: _____

Anesthesia Billing

If any of your procedure(s) is/are billable to your insurance company, please be aware that you will receive a separate bill from anesthesia. Any questions regarding insurance and anesthesia should be directed to anesthesia's billing department.

Patient Initials: _____

Date: _____

Advance Directives

In accordance with Florida law, Coastal Surgery Center must inform you that we are **not** required to honor and **do not honor DNR directives.** A healthcare power of attorney **will** be honored.

If a patient should provide his/her advance directive a copy will be placed on the patient's medical record and transferred with the patient should a hospital transfer be ordered by his/her physician.

At all times the patient or his/her representative will be able to obtain any information they need to give informed consent before any treatment or procedure.

In order to assure that the community is served by this facility, information concerning advance directives is available at the facility. While the state of Florida does not have required a specific form for an advanced directive, free sample forms are available at http://acha.myflorida.com or by calling 1-888-419-3456.

Patient Rights Notification
Each patient at the center will be notified of their rights in the following manner:

- A written notice provided in advance of the day of their surgery in a language and manner the patient understands.
- A verbal notice provided in advance of the day of their surgery in a language and manner the patient understands.
- A posted notice visible by patients and families waiting for treatment.
- Physician ownership/ Physician participation

Patient Signature: _____

Date sent / Presented to patient: _____

By (staff signature): _____
Center retains a copy for file

Patient Grievances
The patient and family are encouraged to help the facility improve its understanding of the patient's environment by providing feedback, suggestions, comments and/or complaints regarding the service needs, and expectations.

A complaint or grievance should be registered by contacting the center and/or a patient advocate at the Florida Department of Health or Medicare (numbers provided in this flyer). The surgery center will respond in writing with notice of how the grievance has been addressed.

Contacts: Coastal Surgery Center, LLC
Kathleen Renner, DNP, APRN-BC, DON
4147 Southpoint Drive, East
Jacksonville, Florida 32216

Medicare Beneficiary Ombudsman
1-800-MEDICARE
1-800-633-4227
www.medicare.gov (Ombudsman link is on left hand column)

Agency for Health Care Administration
Consumer Assistance Unit
2727 Mahan Drive
Tallahassee, Florida 32308
888-419-3456 or 800-487-3183

Accreditation: The Joint Commission
Office of Quality Monitoring
One Renaissance Blvd.
Oak Brook, IL 60181
Phone: 630-792-5800 Fax: 630-792-5636

Living Will

Declaration made this_____ day of_____ 2_____, I _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

_____ I have a terminal condition.
or _____ I have an end stage condition.
or _____I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.
It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequence for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures. I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____ Phone:_____
Address: _____
City:_____ State: _____ Zip: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):
_____
_____
_____

(Signed): _____

Witness: _____
Street Address: 4147 Southpoint Drive East
City, State & Zip: Jacksonville, FL 32216
Phone: (904) 332-6774

Witness: _____
Street Address: 4147 Southpoint Drive East
City, State & Zip: Jacksonville, FL 32216
Phone: (904) 332-6774

The principal's failure to designate a surrogate shall not invalidate the living will.

-This form offered as a courtesy of The Florida Bar and the Florida Medical Association-

Rights of Patients

The following list of patient rights is not intended to be all inclusive. Patients receiving care at our center have a right to:

- Be treated with respect, consideration and dignity.
- Exercise these rights and treated without regard to gender, race, cultural, economic, educational or religious background and without fear of discrimination or reprisal.
- Be treated in a safe environment that is free of physical or psychological threats.
- Expect that any architectural barriers identified will be addressed, and, whenever feasible, such barriers will be modified or corrected.
- Access communication aids (i.e., interpreters, sign language, etc.).
- Be provided appropriate privacy and confidentiality concerning their medical care- the patient has the right to be advised as to the reason for the presence of any individual directly involved or observing their care.
- Be free of restraint except when indicated to protect the patient or others from injury.
- Have their questions, concerns or complaints addressed in good faith.
- Expect continuity of care. The patient will not be discharged or transferred to another facility without prior notice, except in the case of a medical emergency and within the limits of legal regulations.
- Provisions for after-hour and emergency care.
- Access necessary surgical and/or procedural interventions that are medically indicated.
- Obtain any information they need to give informed consent before any treatment or procedure.
- Be provided, to the degree known, complete and timely information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Make choices and decisions regarding their medical care to the extent permitted by law- this includes the right to refuse treatment.
- Formulate advance directives and appoint a surrogate to make health care decisions on their behalf to the extent permitted by law. The provision of the patient's care shall not be conditioned on the existence of an advance directive. (please see the center's policy on advance directives below)
- Have their disclosures and records treated confidentially, and given the opportunity to approve or refuse their release, except when release is required by law.
- Receive, on request, and at a reasonable fee established by the Health Information Management Department, a copy of their medical record.
- Know the services available at the organization.
- Know the facility fees for services.
- Request an itemized statement of all services provided to them through the facility, along with the right to be informed of the payment methodology utilized.
- At their own expense, to consult with another physician or specialist if other qualified physicians or dentists are requested and available.
- Be informed of patient conduct and responsibilities rules.
- Refuse to participate in experimental research.
- Know the identity, professional status, institutional affiliation and credentials of health care professionals providing their care, and be assured these individuals have been appropriately credentialed according to the policies of the center.
- Be informed of their right to change their provider if other qualified providers are available.
- Be provided with appropriate information regarding the absence of malpractice insurance coverage.
- Be informed about procedures for expressing suggestions, complaints and grievances, including those required by state and federal regulations.

Patient Responsibilities

The care of a patient receives depends partially on the patient. Therefore, in addition to these rights, a patient has certain responsibilities that are presented to the patient in the spirit of mutual trust and respect. Patient Responsibilities require the patient 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.
- Make it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
- Follow the treatment plan prescribed by his/her provider.
- Keep appointments and notify surgery center or physician when unable to do so.
- 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.
- Accept responsibility for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Follow our facility's policies and procedures.
- Be respectful of all the health care providers and staff, as well as other patients.

Patient Guardian

The patient's guardian, next of kin, or legally authorized responsible person has the right to exercise the rights delineated on the patient's behalf, to the extent permitted by law, if the patient:

- Has been adjudicated incompetent in accordance with the law.
- Has designated a legal representative to act on their behalf.
- Is a minor.

Physician Participation

This is to inform you that your physician might have a financial interest or ownership in this center. An interest in this facility enables them to have a voice in the administration and medical policies of this health care institution. This involvement helps to ensure the finest quality surgical care for our patients. This involvement helps to ensure the finest quality surgical care for their/our patients. It is your right and responsibility to inquire with your physician/ surgeon as to their financial interest or investments who have a direct or indirect ownership interest.

CSC has an ongoing emphasis on Infection Control practices. And all staff is trained in Infection Control.

Timothy Fee, MD 4147 Southpoint Drive E NPI# 1003876251

LIVING WILLS AND HEALTH CARE ADVANCE DIRECTIVES: FAQ's

The Florida Legislature has recognized that every competent adult has the fundamental right of self- determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment or procedures which would only prolong life when a terminal condition exists. This right, however, is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. To ensure that this right is not lost of diminished by virtue of later physical or mental incapacity, and if desired, to designate another person to act on his or her behalf and make necessary medical decisions upon such incapacity.

What is a Living Will?
Every competent adult has the right to make a written declaration commonly known as a "Living Will." The purpose of this document is to direct the provision, the withholding or withdrawal of life prolonging procedures in the event one should have a terminal condition. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.303. In Florida, the definition of "life prolonging procedures" has been expanded by the Legislature to include the provision of food and water to terminally ill patients.

What is the difference between a Living Will and a legal will?
A Living Will should not be confused with a person's legal will, which disposes of personal property on or after his death, and appoints a personal representative or revokes or revises another will.

How do I make my Living Will effective?
Under Florida law, a Living Will must be signed by its maker in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. If the maker is physically unable to sign the Living Will, one of the witnesses can sign in the presence and at the direction of the maker. Florida will recognize a Living Will, which has been signed in another state, if that Living Will was signed in compliance with the laws of that state, or in compliance with the laws of Florida.

After I sign a Living Will, what is next?
Once a Living Will has been signed, it is the maker's responsibility to provide notification to the physician of its existence. It is a good idea to provide a copy of the Living Will to the maker's physician and hospital, to be placed within the medical records.

What is a Health Care Surrogate?
Any competent adult may also designate authority to a Health Care Surrogate to make all health care decisions during any period of incapacity, the Health Care Surrogate has the duty to consult expeditiously, with appropriate health care providers. The Surrogate also provides informed consent and makes only health care decisions for the maker, which he or she believes the maker would have made under the circumstances if the maker were capable of making such decisions. If there is no indication of what the maker would have chosen, the Surrogate may consider the maker's best interest in deciding on a course of treatment. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.203.

How do I designate a Health Care Surrogate?
Under Florida Law, designation of a Health Care Surrogate should be made through a written document, and should be signed in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. The person designated as Surrogate cannot act as a witness to the signing of the document.

Can I have more than one Health Care surrogate?
The maker can also explicitly designate an Alternate Surrogate. The Alternate Surrogate may assume the duties as Surrogate if the original Surrogate is unwilling or unable to perform his or her duties. If the maker is physically unable to sign the designation, he or she may, in the presence of witnesses , direct that another person sign the document. An exact copy of the designation must be provided to the Health Care Surrogate. Unless the designation states a time of termination, the designation will remain in effect until revoked by its maker.

Can the Living Will and the Health Care Surrogate designation be revoked?
Both the Living Will and the Designation of Health Care Surrogate may be revoked by the maker at any time by a signed and dated letter of revocation; by physically canceling or destroying the original document; by an oral expression of one's intent to revoke; or by means of a later executed document which is materially different from the former document. It is very important to tell the attending physician that the Living Will and Designation of Health Care Surrogate has been revoked.

Where can I go to obtain legal advice on this issue?
If you believe you need legal advice, call your attorney. If you do not have an attorney, call The Florida Bar Lawyer Referral Service at 1-800-342-8011, or the local lawyer referral service or legal aid office listed in the yellow pages of your telephone book.

This information has been prepared by the Consumer Protection Law Committee of The Florida Bar and the Bar's Public Information Office and is offered as a courtesy of The Florida Bar and the Florida Medical Association.