Pre-Operative Health History

Patient Name: _____ MR #: _____ DOB: _____

Assessment Completed by: _____ Date/ Time: _____

YES NO

[ ] [ ] Have you traveled in the last 30 days
[ ] [ ] Are you currently experiencing fever, sore throat or cough (flu like symptoms)
[ ] [ ] Have you been exposed to COVID-19 or been around anyone with fever, cold or flu like symptoms?
[ ] [ ] Instructed not to eat or drink past 12:00 AM for procedures involving sedation (not all procedures in office)
[ ] [ ] Allergies to medications? List: _____ Latex: Y/N
[ ] [ ] Iodine Allergy
[ ] [ ] High blood pressure
[ ] [ ] Angina, chest pain
[ ] [ ] Heart attack, Year: _____
[ ] [ ] Coronary artery disease
[ ] [ ] Coronary bypass surgery, Year:_____
[ ] [ ] Heart stent(s), Year:_____
[ ] [ ] Heart valve, Year:_____
[ ] [ ] Organ transplant: _____Year:_____
[ ] [ ] Immunosuppressants
[ ] [ ] Irregular heart rate, what type:_____
[ ] [ ] Congestive heart failure
[ ] [ ] Leg Swelling/Edema
[ ] [ ] Pacemaker/Defibrillator Cardiologist: _____
[ ] [ ] Tobacco Use:_____pack per day, # of years:_____
[ ] [ ] Vaping/Marijuana use, how often? _____
[ ] [ ] Alcohol use, drinks per week_____
[ ] [ ] Use of pain medication? _____
[ ] [ ] COPD, Home Oxygen
[ ] [ ] Sleep apnea (OSA)/snoring/ use of CPAP
[ ] [ ] Diabetes: Type I Type II (circle)
[ ] [ ] Renal failure, Renal Dialysis
[ ] [ ] Stroke/TI, Any limitations:_____
[ ] [ ] Hepatitis: A, B, C, HIV (circle)
[ ] [ ] Cold sores/fever blisters
[ ] [ ]Tuberculosis (TB)
[ ] [ ] Implants, Type:_____
[ ] [ ] Joint Replacement, Type: _____
[ ] [ ] Previous Surgeries: _____ Year: _____
[ ] [ ] Difficulty with previous anesthetic /History of Malignant Hyperthermia in self or family?
[ ] [ ] History of cancer, type:_____ History of Radiation: _____
[ ] [ ] Pregnant/breastfeeding
[ ] [ ]Taking Aspirin, Coumadin, Plavix, Ibuprofen, Pradaxa, Xarelto, Eliquis, Heparin, Vitamin E, Aleve (any blood thinners)
[ ] [ ] Bleeding Problems
[ ] [ ] Body Piercings: If yes, where: _____
[ ] [ ] History of falls within the last 6 months?
[ ] [ ] Advanced Directive or Power of Attorney **(If yes please bring with to appointment)**

Procedure Type: _____ ASA Classification (Circle): I II III

Reviewed by Medical Provider: _____ Date/ Time: _____

PATIENT'S RIGHTS

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

1) Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for his/her care.
2) Be treated and cared for with dignity & respect.
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 discreetly. 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 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 he/she 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) Confidentiality, privacy, security, complaint resolution (refer to Grievance Procedure), spiritual care and communication. If communication restrictions are necessary for patient care and safety, the Center personnel will document and explain these restrictions to each patient and family member/caretaker.
21) Be protected from abuse and neglect
22) Access protective services
23) Complain about their care and treatment without fear of retribution or denial of care
24) Timely complaint resolution (refer to Grievance Procedure)
25) Be involved in all aspects of their care including:
    (A) Refusing care and treatment
    (B) Resolving problems with care decisions
26) Be informed of unanticipated outcomes
27) Family input in care decisions, in compliance with existing legal directives of the patient or existing court-issued legal orders
28) The right to be informed that Cameron Chesnut, MD has an ownership interest in this center.

PATIENT'S RIGHTS

Complaints may be addressed to Administrator at (509) 456-5949 or to:

Washington State Department of Health
HSQA Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857
Phone: (360) 236-4700
Toll Free: (800) 633-6828
Fax: (360) 236-2626
Email: mailto:HSQAComplaintIntake@doh.wa.gov

Accreditation Association for Ambulatory Health Care, Inc.
5250 Orchard Road, Suite 200
Skokie, Illinois 60077
(847) 853-6060

Center for Medicare and Medicaid Services (CMS)
Office of the Medicare Beneficiary Ombudsman:
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
Medicare Help and Support: 1-800-MEDICARE (1-800-633-4227)

*I have read and understand Chesnut Institute of Cosmetic and Reconstructive Surgery PLLC Patient Rights

_____

Name Printed Date

_____

Signature Date

Chesnut Institute of Cosmetic & Reconstructive Surgery

Admission Agreement, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic and Use and Disclosure of Protected Health Information

Patient name: _____ Date: _____

I authorize and direct my physician(s) _____ , to perform the following procedure(s): _____

_____

and / or such other procedure(s) or any other therapeutic procedure(s) which may deem necessary or advisable, including, but not limited to, the performance of services involving pathology and radiology. Upon my authorization and consent such procedure or special diagnostic or therapeutic procedures will be performed for myself by my physician(s) and / any or other physician or qualified persons selected by them. I understand and agree that the person(s) in attendance for the purpose of administering anesthesia or performing other specialized professional services, such as radiology, pathology and the like, are independent contractors with me and are not employees or agents of the facility or of my physician. The risks include bleeding, infection, paralysis, death, partial pain relief, no pain relief and/or worse pain. My physician has discussed these risks with me. I understand that though they occur rarely, serious life and limb complications can occur as a consequence of these procedures. I understand the nature of the procedure, the expected benefits or effects of such procedure, the medically acceptable alternative procedures or treatments, and that these procedures and special diagnostic or therapeutic procedures all may involve calculated risks or complications, injury or even death. I have a general understanding of the procedure to be performed on me and that no warranty or guarantee has been made as to the result or cure.

Consent to Test for Blood-Borne Diseases

I understand that it may be necessary to test my blood while I am a patient at this Center, in an effort to protect against possible transmission of blood-borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome. If, for example,
a Center employee is stuck by a needle after giving an injection, starting an intravenous fluid, or drawing blood, I understand that my blood as well as the employee's blood will be tested at no charge to the patient. I have been informed that the performance and results of the HIV antibody test are considered confidential. That the test results in my health record shall
not be released without my written permission, except to the individuals and organizations that have been given access by law who are required to keep my health record information confidential.

Consent to Resuscitation

If a patient should suffer a cardiac or respiratory arrest or other life-threatening situation during his/her admission at the Center, the patient authorizes the Center to initiate resuscitation and continue resuscitation techniques until such time as the patient is transferred to the local acute care hospital. The Center will perform necessary life saving measures for all patients until the patient is transferred to the hospital should such methods become necessary during admission at the Center. Do Not Resuscitate (DNR) directives are **NOT** honored at the Center**.**

Tissue Disposal

I hereby authorize the pathologist to use his / her discretion in the disposal of any tissue removed from me during the procedure or procedure described above.

Consent to Transfer

I understand that the procedure to be performed on me at this Center will be done on an outpatient basis and that the facility does not provide for 24-hour patient care. If my attending physician, or any other duly qualified physician in his / her absence, shall find it necessary or advisable to transfer me from the facility to a hospital or other health care facility, I consent and authorize the employees of the facility to arrange for and effect the transfer. In the event that I am transferred to a hospital or other healthcare facility, I consent and authorize for the discharge summaries from the hospital and/or other healthcare facility to be sent to the Center.

Patient Valuables / Personal Property

I have been instructed to leave VALUABLES at home or place them in the care of family members. I understand that the **Center is not responsible for lost or damaged personal property** such as glasses, contact lenses, hearing aids, dentures, jewelry, coats, and / or money.

Payment Obligations

The patient authorizes payment of his / her insurance benefits to the Center. The patient also authorizes payment of any account owed by the patient to this Center out of insurance benefits, with any balance of the said benefits to be paid to the order of the patient. The patient understands that he /she is financially responsible to the Center for charges not covered by any insurance company or any other Third Party. Patient hereby specifically agrees to pay to this Center the patient's outstanding balance at the time of discharge and in accordance with the terms and rates then in effect. The undersigned also acknowledges that they are jointly and separately liable for any and all amounts due and owing as a result of the care rendered by the Center on behalf of the patient. I / We, the undersigned, agree to pay the cost of collection including a reasonable attorney's fee if this account should be placed in the hands of an Attorney for collection suit or otherwise.

Consent to Use and Disclosure of Protected Health Information

My protected health information will be used by the Center or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care procedures of the center. I have had the opportunity of reviewing the Notice of Privacy Practices for a more complete description of how my protected health information may be used or disclosed, and I have reviewed the notice prior to signing this consent. I understand that I may request a restriction on the use or disclosure of my protected health information. The Center may or may not agree to restrict the use or disclosure of my protected health information. If the Center agrees to my request, the restriction will be binding on the center. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. I may revoke this consent to the use and disclosure of my protected health information. I must revoke this consent in writing. Any use or

disclosure that has already occurred prior to the date on which my revocation of consent is received will not be affected. The Center reserves the right to modify the privacy practices outlined in the notice. I have reviewed this consent form and give my permission to the Center to use and disclose my health information in accordance with it.

Photography Consent

I consent to the photographing and / or videos of the procedure, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them.

Observer Consent

I consent to an observer in the operating room for medical, scientific, or educational purposes, provided my identity is not revealed to the observer.

Students

I understand that this center participates in student education such as nursing and technician school rotation. I understand that a student may be involved in my care.

Advance Directives

Upon registration, we will ask you if you have an advance directive. An advance directive is a written document, which communicates your health care wishes clearly. A copy of your advance directive must be placed in your medical record. There are two types of advance directives:

A Durable Power of Attorney for Health Care

Is a document that allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to, the withholding or withdraw of life prolonging procedures.

A Living Will or Health Care Directive

Is a document that allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

Initials: _____

Certification

The undersigned certifies that he / she has read and understood the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this agreement and consent to and accept its terms. The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information.

Following the procedure, if conscious sedation was administered I will have a responsible person drive me home and I have made arrangements for this. I realize that impairment of full mental alertness may persist for several hours following the administration of conscious sedation and I will avoid making decisions or taking part in activities, which depend upon full concentration or judgement during that period. Written instructions have been explained and a copy has been given to me.

I have reviewed this Admission Agreement, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic and Use and Disclosure of my Protected Health Information.

I do hereby acknowledge the receipt of my copy of this center's Patient Rights, Advance Directive Policy, and Notice of Ownership prior to this date

_____
Patient / Parent / Guardian Signature

(If patient is a minor or unable to sign, complete the following):
Patient is a minor or unable to sign because: _____
_____
_____

_____
Witness

_____
Date Time

Consent for the Administration of Anesthesia

I have been informed by the center of the following types (s) of anesthesia that may be used:

***Local Anesthesia** ***Local Anesthesia with IV Sedation** ***Anesthesia**

Significant risks and complications of the anesthesia to be administered have been explained and include but are not limited to: Sore Throat, Nausea, Vomiting, Upper Respiratory Infection, Bronchitis, Pneumonia, Chipped Teeth, Cardiac Arrhythmia, Cardiac Arrest, or Respiratory Arrest. Complications related to the intravenous lines such as: phlebitis, nerve damage, infiltration, etc. I accept these risks and hereby consent to the administration of anesthetics. No warranty or guarantee has been made as to the results thereof.

_____ _____
Patient/Parent/Guardian Signature Time Witness