Welcome to…

The Physicians Surgery Center!

Pre-Admission Procedures

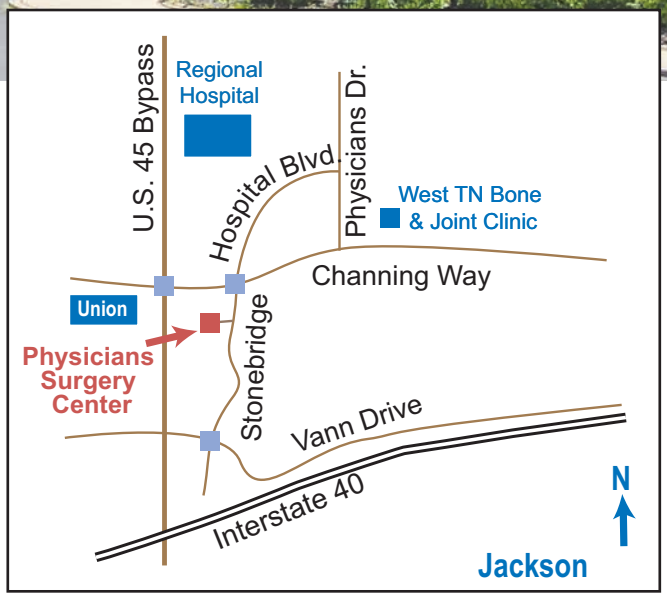
We are looking forward to having you as a patient. To help make sure your visit goes smoothly, we ask that you have a pre-admission/registration interview at the Physicians Surgery Center at least a week before your scheduled procedure.

The pre-admission process eliminates the need for additional time for testing or paperwork on the day of your procedure. It also allows the physician to view your results before your surgery. This, in turn, reduces any delay due to abnormal lab work that is completed 72 hours before surgery.

The pre-admission process includes an admission/registration interview, the gathering of insurance information, a nursing history and physical, and any pre-admission testing required before your procedure. The entire process could take up to two hours.

Here's what you should do...

■ Come to the Physicians Surgery Center at 207 Stonebridge Blvd. in Jackson. We are open 8 a.m. to 4:30 p.m. Monday through Friday. (We are closed on major holidays.)



Driving instructions: From U.S. 45 Bypass North, go east on Channing Way. At first stoplight, turn south (right) onto Stonebridge. The entrance to the Physicians Surgery Center is on your right.

■ No appointment is necessary, but you may call ahead at 731-661-6340.

■ Please bring with you: Your insurance cards, a list of all medications you are currently taking, the pre-admission form (filled out) on the back of this sheet, and a copy of your Living Will or Durable Power of Attorney (if you have one).

■ Fasting is not required for pre-admission lab work unless your doctor tells you to fast.

■ You will be given any special instructions you need to follow before your procedure, as well as driving instructions for the day of your procedure.

PHYSICIANS
SURGERY CENTER

Date	Patient Information	Age	Sex	Race

Last Name	First Name	MI

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Date of Birth	Marital Status

Social Security Number	Email Address

Employer	Emergency Contact Number

Insurance Information

(Skip, If Worker's Comp or Liability)

Primary Insurance Name	Policy Holder's Name	Policy Holder's DOB

Policy #	Group #	Relationship of Policy Holder to Patient

Secondary Insurance Name	Policy Holder's Name	Policy Holder's DOB

Policy #	Group #	Relationship of Policy Holder to Patient

IF PATIENT'S A MINOR, PLEASE FILL OUT THIS SECTION

Parent's Full Name	Address(If Different)	Parent's Social Security No.	

Parent's DOB	Home Phone	Work Phone	Cell Phone

Physicians Surgery Center
Preoperative Evaluation

Sex(Circle): M F Age:_____ Height:_____ Weight:_____

Proposed Surgical Procedure:_____

Previous Surgery:_____

_____

Anesthesia Problems or Family History of Anesthesia Problems:_____

_____

HISTORY

Check Yes or No

General:_____

Glaucoma [ ] Yes [ ] No
Serious Illness [ ] Yes [ ] No
Dentures [ ] Yes [ ] No
Bleeding Problems [ ] Yes [ ] No
Hearing Loss [ ] Yes [ ] No
Alcohol/Drug Abuse [ ] Yes [ ] No
Smoke [ ] Yes _____ Packs [ ] No
Anemia [ ] Yes [ ] No
Arthritis [ ] Yes [ ] No

Cardiovascular:_____

Heart Attack [ ] Yes [ ] No
High Blood Pressure [ ] Yes [ ] No
Angina [ ] Yes [ ] No
Congestive Heart Failure [ ] Yes [ ] No
Poor Circulation [ ] Yes [ ] No
Coronary Artery Disease [ ] Yes [ ] No
Pacemaker [ ] Yes [ ] No
Defibrillator [ ] Yes [ ] No

Respiration:_____

Pneumonia [ ] Yes [ ] No
Asthma [ ] Yes [ ] No
Emphysema [ ] Yes [ ] No
Recent Upper Resp. Infection [ ] Yes [ ] No
Shortness of Breath [ ] Yes [ ] No
Tuberculosis [ ] Yes [ ] No
Oxygen Use/CPAP [ ] Yes [ ] No

GI:_____

Liver Disease [ ] Yes [ ] No
Hepatitis [ ] Yes [ ] No
Stomach Problems [ ] Yes [ ] No

GU:_____

Frequent Kidney Infections [ ] Yes [ ] No
Renal Failure [ ] Yes [ ] No
Kidney Disease [ ] Yes [ ] No
Dialysis [ ] Yes [ ] No

Claustrophobia (Circle): Yes No
Sleep Apnea/ CPAP (Circle): Yes No

Metabolic:_____

Diabetes [ ] Yes [ ] No_____
Age of Onset:_____
Rx Oral:_____
Insulin:_____
Control:_____

Neurology:_____

Epilepsy/Seizures [ ] Yes [ ] No
Frequent Headaches [ ] Yes [ ] No
Difficulty Walking [ ] Yes [ ] No
Dizziness [ ] Yes [ ] No
Back/Neck Disorder [ ] Yes [ ] No
Stroke [ ] Yes [ ] No

Cancer History:_____

_____

_____

Current Medical Doctor:_____
Date of Last Physical Exam:_____

Staff Use Only Below This Line

**Prescription for Emend 40mg PO given to general anesthesia patients to take the morning of their surgery per anesthesia protocol [ ] Yes [ ] No [ ] NA

Nurse Signature:_____ Date:_____

Advance Directives:

As noted in the patient rights listed on preceding pages, you have the right to be involved in your healthcare plan and make choices about your healthcare treatment. Sometimes, medical care cannot cure a deadly illness or injury. You have the right to stop or prevent treatment if you do not believe it is beneficial. These instructions are known as an Advance Directive. They should be written and discussed with your family and medical team. Your Advance Directive may include end-of-life treatment choices that provide direction to your family and medical team to assure that your care is provided with dignity, comfort and the support of your loved ones. This document explains how to give instructions to your doctors to help you avoid medical treatment that you may not want.

What is an Advance Directive?
Advance Directives are documents that express your wishes if you are very ill or unconscious and cannot speak for yourself. By completing an Advance Directive before you are very ill or injured, you let your doctor and family know what you want.

What does the law say about Advance Directives?
The Federal Patient Self-Determination Act of 1990 and the 2004 Tennessee Healthcare Decision Act describe your rights to accept and/or refuse treatment. These acts require all healthcare providers to give you written information like this, to ask you if you have advance directives and to write down your answers. If you have an advance directive, bring it with you when you check in to the hospital. Someone here must put a copy of it in your patient record. You can also ask someone questions about advance directives. Blank forms are available on request when your check into the hospital.

Why should I complete an Advance Directive?
Without an Advance Directive, your family or friends could have a hard time making decisions for you, and your doctors might not know who should make the decisions for you. Signing an Advance Directive is a gift for your loved ones, making it easier for them to carry out your wishes and helping them ensure you get treatment that is right for you.

Do I have to complete an Advance Directive?
No. No one can force you to complete an Advance Directive. You cannot be denied care because you do not have an Advance Directive.

Tennessee Advance Directives
In Tennessee, we have two kinds of Advance Directives. An Advance Care Plan (called a Living Will) lets you write down your choices. An Appointment of Healthcare Agent (Durable Power of Attorney for Healthcare or Healthcare Proxy) lets you assign a family member, friend, or other person to make decisions for you when you cannot. If you have an Advance Directive that is properly completed, Physicians Surgery Center will not honor this. If an emergency arises, you will be transferred to a facility that will. To obtain copies of these forms, ask your caregiver.

Living Will/Advance Care Plan:

What is a Living Will/Advance Care Plan?
This is a legal form that lets you say you don't want to be kept alive in certain situations or that you do wish to be kept alive if at all possible. Unlike a normal will, a Living Will/Advance Care Plan says nothing about who gets your money when you pass away. It does allow you to avoid certain treatments, if that is your wish, and to make decisions about your medical care.

What treatments can I refuse?
You can choose to refuse many medical and surgical treatments, including food and water. In the Tennessee Advance Care Plan form we provided in this booklet, you can choose to avoid: (please see form for details)

- CPR (Cardiopulmonary Resuscitation)
- Life Support/Other Artificial Support
- Treatment of New Conditions
- Tube Feeding/IV Fluids

If you want, you can add other choices to the form. Talk with your doctor about other treatments you might want to refuse.

Durable Power of Attorney for Healthcare/ Appointment of Healthcare Agent:

What is a Durable Power of Attorney for Healthcare/Appointment of Healthcare Agent?
Here's how it works: You name a person to make healthcare decisions for you in the event you cannot speak for yourself. This person is called your agent. Your agent should be someone you trust and know well. Talk with your agent. Explain in detail what care you would want if you were sick or hurt. A healthcare agent can agree to refuse or take away any kind treatment. Make sure they understand your choices and are prepared to carry out your wishes. That way, your agent can make the right choices for you.

Please note: *A Durable Power of Attorney for Healthcare or Appointment of Healthcare Agent doesn't allow someone to make financial decisions for you.*

How can I make sure that people know about my Advance Directives?
The simplest way is to make copies. Give copies to your doctor, your family and close friends and to your healthcare agent. Bring a copy whenever you go into the hospital, a nursing facility or to a new doctor.

What else should I know about Advance Directives?
When executing a written advance care plan in Tennessee:

- Advance Directives may be witnessed by two witnesses or notarized
- Healthcare center employees may act as one of the witnesses
- Witnesses may not be the agent (attorney-in-fact) and at least one may not be related to the patient in any manner nor entitled to any portion of the principal's (patient's) estate upon his/her death.
- Anyone wishing to complete an Advance Directive must be at least 18 years of age.

Organ Donation:

Can I use these forms to become an organ donor?
The Tennessee Advance Care Plan lets you decide in advance to become an organ and tissue donor. Indicate your choice in the section on the form. Make sure your family understands your decision. This is important because without a clear expression of your decision, your gift could be lost.

For complete information about organ and tissue donation, please contact Tennessee Donor Services at (423) 756-5736.

Thank you for reading this information. You don't need a lawyer to complete these forms, but if you need legal advice, please contact an attorney.

Sign:_____ Date:_____

Witness:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

Physicians Surgery Center- 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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give your health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donations agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about your for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required in agree to such restriction, but if we do agree, we must abide by those restrictions.
Confidential Communication: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting f Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
Neal Rager
Administrator

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:
_____

Date: _____

If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement:

_____ Date: _____