

MEMORIALCARE OUTPATIENT SURGICAL CENTER LONG BEACH

Dear Patient:

Welcome to the MemorialCare Outpatient Surgical Center Long Beach. We are pleased that you have placed your trust in us to provide your healthcare services.

MemorialCare Outpatient Surgical Center Long Beach was designed to provide patients with a more efficient and less stressful environment. Our pleasant atmosphere and highly qualified staff can minimize the anxiety that often comes with having a procedure.

In the days before the procedure, you may be contacted by a representative from our facility to discuss pre-operative preparation and answer any questions you may have. During this call, we will verify your appointment and arrival time to the facility. In view of the fact that you will be sedated or receive anesthesia during your visit, it is imperative that a responsible adult drive you home from the facility, a taxi/hired driver is not acceptable. Unfortunately, we cannot make any exceptions to this requirement.

When you come to MCOSCLB, if you require glasses, hearing aid, an inhaler as needed, or any other accessory items needed for your care, please bring them with you. We ask that you do not bring any jewelry or other valuables to the Center. In addition, please bring your **Driver's License or other form of legal I.D., insurance cards, and a form of payment (if informed of payment)**.

If you have an Advance Directive or Living Will, please bring this with you the day of the procedure. It is our policy not to honor Advance Directives during your care at MCOSCLB. However, it will be placed in your medical record in the event that there is a patient transfer or emergent situation. If you need additional information regarding Advance Directives, we will be happy to provide you with official State Advance directive forms. Please refer to CA Probate Code Section 4701 ag.ca.gov.

Our goal is to provide a safe, friendly environment in which your concerns are addressed promptly to your satisfaction. We will make every attempt to honor your trust by providing the high quality medical care you expect and deserve. We welcome any comments and suggestions you may have.

If you have any further questions, please call us at 562-426-2606. One of our highly qualified team members will be happy to assist you.

Sincerely,

Yeneira Cardenas
Yeneira Cardenas
Physician Office Liaison

Surgical Care Affiliates

Patient Rights and Responsibilities



SCA
Surgical Care Affiliates®

SCA observes and respects a patient's rights and responsibilities without regard to age, race, color, sex, national origin, religion, culture, physical or mental disability, personal values or belief systems.

You have the right to:

- Considerate, respectful and dignified care and respect for personal values, beliefs and preferences.
- Access to treatment without regard to race, ethnicity, national origin, color, creed/religion, sex, age, mental disability, or physical disability. Any treatment determinations based on a person's physical status or diagnosis will be made on the basis of medical evidence and treatment capability.
- Respect of personal privacy.
- Receive care in a safe and secure environment.
- Exercise your rights without being subjected to discrimination or reprisal.
- Know the identity of persons providing care, treatment or services and, upon request, be informed of the credentials of healthcare providers and, if applicable, the lack of malpractice coverage.
- Expect the facility to disclose, when applicable, physician financial interests or ownership in the facility.
- Receive assistance when requesting a change in primary or specialty physicians, dentists or anesthesia providers if other qualified physicians, dentists or anesthesia providers are available.
- Receive information about health status, diagnosis, the expected prognosis and expected outcomes of care, in terms that can be understood, before a treatment or a procedure is performed.
- Receive information about unanticipated outcomes of care.
- Receive information from the physician about any proposed treatment or procedure as needed in order to give or withhold informed consent.
- Participate in decisions about the care, treatment or services planned and to refuse care, treatment or services, in accordance with law and regulation.
- Be informed, or when appropriate, your representative be informed (as allowed under state law) of your rights in advance of furnishing or discontinuing patient care whenever possible.
- Receive information in a manner tailored to your level of understanding, including provision of interpretative assistance or assistive devices.
- Have family be involved in care, treatment, or services decisions to the extent permitted by you or your surrogate decision maker, in accordance with laws and regulations.
- Appropriate assessment and management of pain, information about pain, pain relief measures and participation in pain management decisions.
- Give or withhold informed consent to produce or use recordings, film, or other images for purposes other than care, and to request cessation of production of the recordings, films or other images at any time.
- Be informed of and permit or refuse any human experimentation or other research/educational projects affecting care or treatment.
- Confidentiality of all information pertaining to care and stay in the facility, including medical records and, except as required by law, the right to approve or refuse the release of your medical records.
- Access to and/or copies of your medical records within a reasonable time frame and the ability to request amendments to your medical records.
- Obtain information on disclosures of health information within a reasonable time frame.
- Have an advance directive, such as a living will or durable power of attorney for healthcare, and be informed as to the facility's policy regarding advance directives/living will. Expect the facility to provide the state's official advance directive form if requested and where applicable.
- Obtain information concerning fees for services rendered and the facility's payment policies.
- Be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

- Be free from all forms of abuse or harassment.
- Expect the facility to establish a process for prompt resolution of patients' grievances and to inform each patient whom to contact to file a grievance. Grievances/complaints and suggestions regarding treatment or care that is (or fails to be) furnished may be expressed at any time. Grievances may be lodged with the state agency directly using the contact information provided below.

If a patient is adjudged incompetent under applicable State laws by a court of proper jurisdiction, the rights of the patient will be exercised by the person appointed under State law to act on the patient's behalf.

If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

You are responsible for:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Identifying any patient safety concerns.
- Observing prescribed rules of the facility during your stay and treatment.
- Providing a responsible adult to transport you home from the facility and remain with you for 24 hours if required by your provider.
- Reporting whether you clearly understand the planned course of treatment and what is expected of you and asking questions when you do not understand your care, treatment, or service or what you are expected to do.
- Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications—including over-the-counter products and dietary supplements, and any allergies or sensitivities, unexpected changes in your condition or any other patient health matters.
- Promptly fulfilling your financial obligations to the facility, including charges not covered by insurance.
- Payment to facility for copies of the medical records you may request.
- Informing your providers about any living will, medical power of attorney, or other advance directive that could affect your care.

You may contact the following entities to express any concerns, complaints or grievances you may have:

FACILITY	James J Hogan, Administrator 3833 Worsham Avenue, Suite 200 Long Beach, CA 90808 562-426-2606
STATE AGENCY	MedicalBoard of California - Complaint Unit 2005 Evergreen Street, Suite 1200 Sacramento, CA 95818-3831 www.mbc.ca.gov 916-263-2528
MEDICARE	Office of the Medicare Beneficiary Ombudsman: www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
ACCREDITING ENTITY	AAHC (Accreditation Association for Ambulatory Health Care) 5250 Old Orchard Road, Suite 200 Skokie, IL 60077 847-853-6060 www.aaahc.org

To care for our patients, serve our physicians, and improve healthcare in America

MEMORIALCARE OUTPATIENT SURGICAL CENTER LONG BEACH

Patient History Questionnaire

Patient Name: _____ Age: _____ D.O.B.: _____ Today's Date: _____

Date of Surgery: _____ Type of Surgery: _____

Surgeon: _____ Height: _____ Weight: _____

Please answer yes or no to every question. Circle all applicable conditions and symptoms.

	Yes	No
1. Have you ever had any problems with previous heart disease, palpitations or angina? Please list: _____		
2. Do you have a pacemaker or AICD? Model and make: _____		
3. Do you have any problems with high or low blood pressure? Please list BP meds on medication form _____		
4. Have you had any breathing problems, asthma, hay fever, chronic bronchitis, emphysema, shortness of breath or sleep apnea? _____		
5. Have you had any seizures, convulsions, migraine headaches, fainting spells or stroke? _____		
6. Have you had jaundice, hepatitis, liver disease or blood transfusion reactions? _____		
7. Do you have diabetes, hypoglycemia or thyroid problems? _____		
8. Do you take insulin? If "yes," oral, injection or pump? _____		
9. Do you have kidney problems? _____		
10. Have you had a cold, sore throat, or flu in the last two weeks? _____		
11. Have you had (or been exposed to in the last 2 weeks) chicken pox, mumps, measles (rubella), German measles (rubella)? _____		
12. Do you have any physical disabilities, back pain, arthritis or bursitis? _____		
13. Any other medical condition? What? _____		
14. Have you ever had motion sickness? _____		
15. Do you smoke? _____ Number of packs per day _____ Number of years _____		
16. Do you drink alcohol? If "yes," how many drinks per day? _____ per week? _____		
17. Do you have any loose teeth, dentures, permanent or removable bridges or front teeth capped? _____		
18. Do you wear contact lenses? _____		
19. Do you have any difficulty opening your mouth? _____		
20. Have you or any blood relative had an unusual reaction to anesthesia or had malignant hyperthermia? _____		
21. Are you allergic to anything? What? _____		
22. Within the last two months have you taken cortisone or steroids? _____		
23. Within the last two weeks have you taken a tranquilizer, diet pills or herbal medications? Please list on medication form _____		
24. Have you taken any medication today? Please list on medication form: _____		
25. Do you use recreational drugs? Please list: _____		
26. Could you be pregnant at this time? _____ Date of last menstrual cycle _____		
27. Last date of Flu vaccine _____; Pneumonia vaccine _____; Hepatitis vaccine _____		

PREVIOUS SURGERIES			
Procedure	Date	Type Anesthesia	Complications

COMPLETED BY: _____ Date: _____ Time: _____

RELATIONSHIP TO PATIENT: _____

Signature Assessment Nurse - Initials - Date/Time

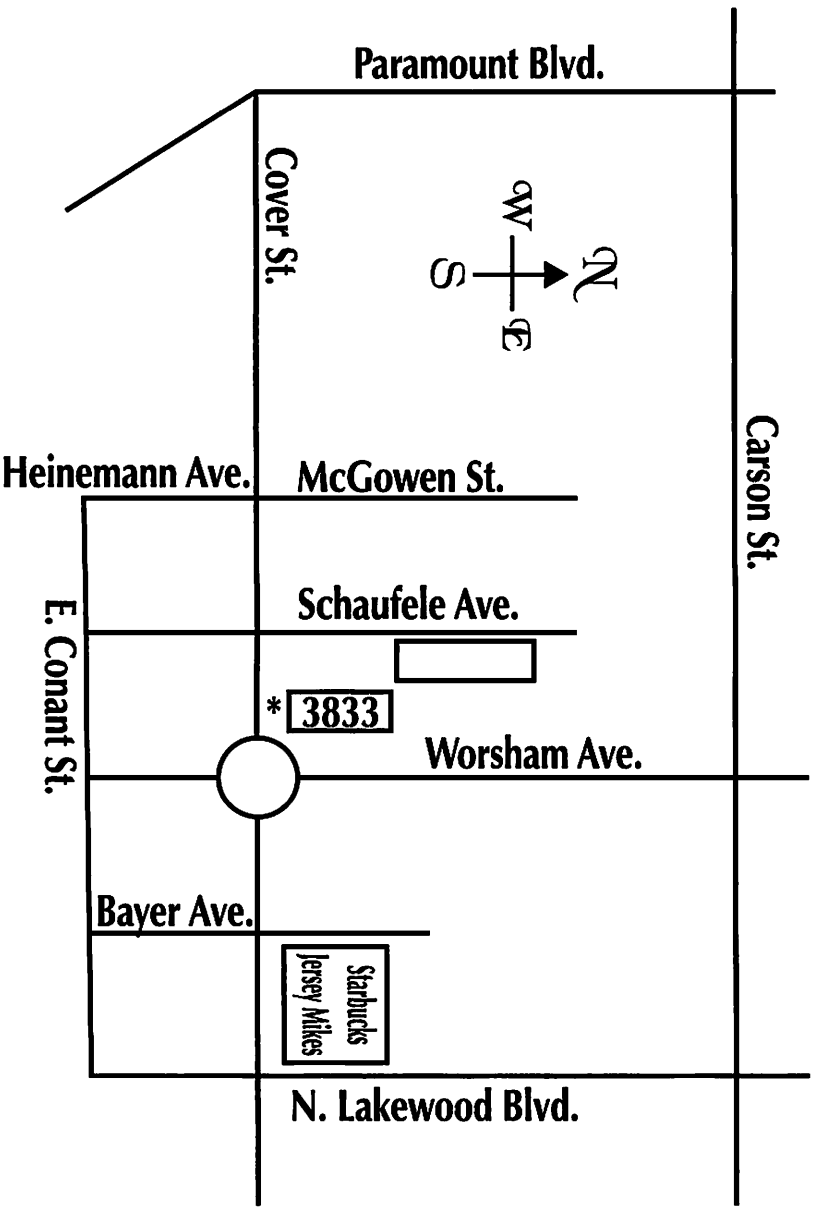
Signature Intra-procedure RN - Initials - Date/Time

Signature PACU Nurse - Initials - Date/Time



**PATIENT STATED MEDICATION LIST
Medication Reconciliation**

Patient Name:				
Date of Surgery/Procedure:			Form completed by:	
ALLERGIES: List all allergies to medications, herbs, food, latex, IV contrast or dye, etc. Describe the reaction to the allergy. Example: Sulfa- rash <input type="checkbox"/> NONE				
MEDICATIONS: List your Prescriptions, Herbal and Over-the Counter medicines you take. <input type="checkbox"/> NONE <input type="checkbox"/> Patient poor historian/No family present/Unable to obtain information at this time.				
Medication Name	Dose	Frequency	Purpose	Last Taken: Date/Time
Reviewed by:	Pre-op RN:	Date/Time	PACU RN:	Date/Time
Reviewed by Intra Op – RN:		Date/Time		
PRESCRIPTIONS GIVEN <input type="checkbox"/> Yes <input type="checkbox"/> No				
Patient Instructions: Above is a list of medications that you indicated you are currently taking. Unless otherwise noted, you should resume taking these medications. Please contact the physician who prescribed your medications if you have any questions. In addition, any medication that has been prescribed as a result of your visit has been noted as well. Your signature below means you understand these instructions.				
Patient/Patient Representative				Date/Time



MemorialCare Outpatient Surgical Center Long Beach is located on Cover Street, between Worsham Avenue and Schaufele Avenue.



3833 Worsham Avenue, Suite 200
 Long Beach, California 90808
 562/426-2606



MEMORIALCARE HEALTH SYSTEM

Excellence in Health Care

MemorialCare Outpatient Surgical Center Long Beach

an affiliate of SCA

Your Physician may be a partner in MemorialCare Outpatient Surgical Center Long Beach, a joint venture which was developed between local physicians and Surgical Care Affiliates and MemorialCare, to provide a cost-effective alternative to hospital based surgical care. MemorialCare Surgical Center Long Beach is committed to providing quality outpatient surgical services, and is accredited by AAAHC the Accreditation Association of Ambulatory Health Care.

While MemorialCare Outpatient Surgical Center Long Beach has been recommended as a location for your procedure, the choice of where to obtain these services is solely yours.

LIMITED PARTNERS

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