PATIENT INFORMATION PACKET:
TO BE FILLED OUT AND PLACED IN DROPBOX OR FAXED IN AS SOON AS POSSIBLE AND/OR BROUGHT WITH YOU ON DAY OF SURGERY. PLEASE CALL THE DAY BEFORE YOUR SURGERY FOR ARRIVAL TIME IF NOT CONTACTED BY THE FACILITY.

RIVERSIDE OUTPATIENT SURGICAL INSTITUTE (ROSI)

4500 Brockton Ave., Suite 105 | Riverside, CA 92501
951.784.4088 | fax: 951.784.4089
SCHEDULING@RiversideOutpatientSurgicalInstitute.com

Dear Patient, _____
Name:

We are excited that your physician and you have chosen Riverside Outpatient Surgical Institute for your procedure:

Date: Mon | Tue | Wed | Thurs | Fri | Sat

Our clinical staff will be contacting you regarding your arrival time, pre-operative/procedure needs and our business office will be contacting you regarding your insurance obligations. Listed below are documents included in this packet that **require to be filled out and acknowledgement prior to your arrival to our facility.**

Please sign and date these papers prior to your surgery/procedure date. (Failure to comply could result in postponement/cancellation of your procedure.)

Please bring the completed documents with you to expedite your admitting process.
List of documents (check when you complete):

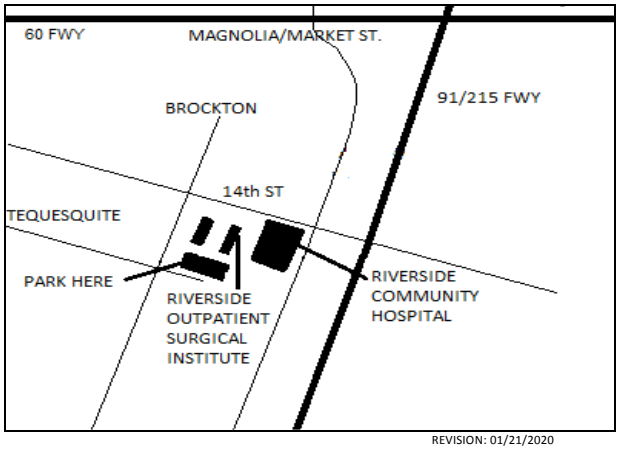
DOCTOR'S OFFICE TO DROPBOX OR FAX ALL WHITE PAGES, AND PATIENT TO BRING ALL DAY OF SURGERY*

- □ **Patient Information Form** **
- □ **Driver's license & Insurance card** **
- □ **History & Physical** **
- □ **Past Medical History Questionnaire** **
- □ **Caprini Thrombosis Risk Assessment** **
- □ **Medication Reconciliation List** **
- □ **State of California Survey**
- □ **Physician Disclosure of Ownership** **
- □ **Conditions of Coverage & Patient Attestation** **

All colored sheets informational: Mission Statement, Notice of Privacy Policies 2 pgs, Patient Rights and Responsibilities, Advance Directive information, Patient General Pre-op Instructions, Reduce Your Risk of Infection

Before your surgery, please visit our website:
WWW.RIVERSIDEOUTPATIENTSURGICALINSTITUTE.COM

*We are located on the first floor of the **Evans Park Medical Arts Building** directly adjacent to The Cancer Center at Riverside Community Hospital. **Look for the awning with 4500 printed on it. See address above.***
We look forward to seeing you!
The staff at Riverside Outpatient Surgical Institute



PATIENT INFORMATION

Patient's Legal Name: SS#

Address: City: State: Zip:

Driver License #: State: Gender: ☐ Male ☐ Female

E-Mail Address:

Date of Birth: Age: Marital Status: Home Phone: ( )

Allergies/Drug Hypersensitivities: Cell Phone: ( )

Employer: Business Phone: ( )

Business Address City: State: Zip:

Name of Spouse/Parent: SS#

Spouse/Parent Address: City: State: Zip:

Spouse/Parent Home Phone: ( ) *(if patient is minor)* Parent Driver License# State

Spouse/Parent Employer: Business Phone: ( )

EMERGENCY CONTACT

Contact Telephone #: ( ) Name Relationship:

INSURANCE/PAYMENT INFORMATION:

Type of Payment: ☐ Insurance *(attach photocopy of information)* ☐ Cash ☐ Lien *(attach Lien document)*

Primary Insurance _____ Policy #: _____ Policy Holder: _____

Secondary Insurance Policy #: Policy Holder:

Patient/Responsible Adult Signature: ✕ Date:

Patient/Responsible Adult Print Name: *Relationship to Patient

**If signed by person other than patient*

Interpreter (If required) Signature: Print Name

Interpreter relationship to patient (if applicable)

Fill out this section ONLY if you accept financial responsibility for the patient for whom you have NO legal responsibility.

I, the undersigned person, hereby certify that I have accepted total financial responsibility for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and clinical care workers. I understand that I do not currently have any legal responsibility to provide financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to the patient by Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. Please fill in all sections below and sign where indicated.

Last Name: First M.I. SS#:

Relationship to Patient: Home phone: Date of Birth:

Address: City State Zip

Driver License OR other photo ID: # Type of ID: State issued:

Occupation: Employer: Bus Phone:

Signature of Responsible Party Print Name:

LEFT SIDE OF CHART

HISTORY & PHYSICAL

If H&P not completed within 30 days prior to admission, complete all pertinent sections below.

Date: Time: | Referring Physician/person:

Chief Complaint:

History of Present Illness/Reason for Visit:

Current Medications: ☐ - See attached sheets

Allergies: ☐ - See attached sheets

Previous Surgical History: ☐ - See attached sheets

PMH/ROS: ☐ See attached sheets.

☐ Y ☐ N Respiratory: _____
Asthma, Bronchitis, COPD, Dyspnea, Orthopnea, Pneumonia, Chronic Cough, SOB, Recent URI, Tuberculosis, Hx of DVT, PE in family or self

☐ Y ☐ N Cardiovascular: _____
Abnormal EKG, Angina, ASHD, CHF, Exercise Intolerance, CVA/Stroke/ TIA, Hypertension, MI, Murmur, Pacemaker, Valvular Disease Rheumatic Fever

☐ Y ☐ N Hepato/Gastrointestinal _____
Bowel Obstruction, Cirrhosis, Jaundice/Hepatitis, Hiatal, Hernia/Reflux, Chronic Nausea/Vomiting, Ulcers, UTI

☐ Y ☐ N Neuro/Musculoskeletal: _____
Arthritis, Back problems, CVA/Stroke/TIA, Headaches, Ulcers Muscle Weakness, Syncope, Seizures, Paralysis, Paresthesia

☐ Y ☐ N Renal/Endocrine: _____
Diabetes, Renal failure, Thyroid disease, Urinary retention, Significant Weight Loss/Gain

☐ Y ☐ N Other: _____
Anemia, Bleeding tendencies, Cancer, Chemotherapy, Sickle Cell, Immunosuppressed, Pregnancy, Recent steroid use, Blood Transfusion

Smoking/Vaping/Cannabis: **☐ Y ☐ N** ___ # packs per day/week Alcohol Use: **☐ Y ☐ N** Frequency: __ Drug Use: **☐ Y ☐ N** Freq: ___ Is there any history of the following medical conditions in your *family*? ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke

☐ Lung Disease ☐ Diabetes ☐ Bleeding Disorder ☐ Cancer ☐ Other: _____

Previous surgical/anesthesia complications (patient or family) ☐ No ☐ Yes. Describe: _____

PE: Ht: Wt: BMI: B.P.: Pulse: Temp: Pain Level: /10

General	☐ - WNL
Head & Neck	☐ - WNL
Heart/Lungs	☐ - WNL
Breast	☐ - WNL
Abdomen	☐ - WNL
Extremities	☐ - WNL
Neurological	☐ - A&O x 3

Impression/Assessment

Consent:

☐ I have determined that this patient is a suitable candidate for the planned procedure at this facility. I have explained the procedure/surgery, including appropriate alternatives, benefits, side effects and risks. I have answered all the patient's/guardian's questions. The patient/guardian accepts the proposed procedural/surgical plan.

Physician Signature: **Date/Time:**

History and Physical Update: (please sign/date/time if H & P done within 30 days)

☐ No change in patient condition noted after patient examination & review of H&P and admission patient history. I have determined that this patient is a suitable candidate for the planned procedure at this facility today.

☐ Change in patient condition noted after patient examination & review of H&P and admission patient history:

Describe: _____

_____ _____

Signature of Physician Date/Time

PRE-OPERATIVE

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS QUESTIONNAIRE

(CIRCLE ALL THAT APPLY)

PAST MEDICAL HISTORY	COMMENTS
Respiratory: ☐ **- NONE** Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease, Difficulty Breathing, Pneumonia, Chronic Cough, Shortness of Breath, Recent Upper Respiratory Infection, Tuberculosis, History of Deep Vein Thrombosis, Pulmonary Embolism in family or self, Sleep Apnea	
Liver/Gastrointestinal: ☐ **- NONE** Bowel Obstruction, Cirrhosis, Jaundice/Hepatitis, Hiatal Hernia/Reflux, Chronic Nausea/Vomiting, Ulcers, Urinary Tract Infection, Ulcers	
Renal/Endocrine: ☐ **- NONE** Diabetes, Renal failure, Thyroid disease, Urinary retention, Significant Weight Loss/Gain.	
Cardiovascular: ☐ **- NONE** Abnormal EKG, Irregular Heart Beat, Angina, Heart Attack, Arteriosclerosis Heart Disease, Congestive Heart Failure, Exercise Intolerance, Hypertension, Murmur, Pacemaker, Valvular Disease, Rheumatic Fever.	
Neuro/Musculoskeletal: ☐ **- NONE** Difficulty Opening Mouth for Dentist, Arthritis, Back problems, Cerebrovascular Accident/Stroke/Transient Ischemic Attack, Headaches, Muscle Weakness, Syncope, Seizures, Epilepsy, Paralysis, Paresthesia, Depression, Anxiety	
Other: ☐ **- NONE** Anemia, Sickle Cell Anemia, Bleeding tendencies, Cancer, Chemotherapy, Immunosuppressed, Pregnancy, Recent steroid use, Blood Transfusion, HIV, Loose/Damaged Teeth, Caps, Crowns, Bridges, Dentures, Piercings, Metal Implants	
Do you smoke? How many packs per day? Smokeless Tobacco ☐ **- NO or Describe in comments**	
Do you drink alcohol? How frequent? ☐ **- NO or Describe in comments**	
Do you use recreation drugs? What and how frequent? ☐ **- NO or Describe in comments**	
IS THERE ANY FAMILY HISTORY OF:	
Do you, or is there a family history of anesthesia problems following General Anesthesia but not limited to the following; High fever after receiving General Anesthesia, A family or personal history of Malignant Hyperthermia, a muscle or neuromuscular disorder, high temperature following exercise; a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise. ☐ **- NO or Describe in comments**	
High Blood pressure? ☐ **- NO or Describe in comments**	
Heart Disease ☐ **- NO or Describe in comments**	
Stroke ☐ **- NO or Describe in comments**	
Lung Disease ☐ **- NO or Describe in comments**	
Diabetes ☐ **- NO or Describe in comments**	
Bleeding Disorder ☐ **- NO or Describe in comments**	
Cancer ☐ **- NO or Describe in comments**	
Previous Surgery and date(s): ☐ **- None or Please describe:**	
Any complications? ☐ **- None or Please describe:**	
Is there anything we should be aware of that is not listed here? ☐ **- None or Please describe:**	
Allergies/Medication Sensitivities with Reaction:	
Do you take any Prescription, Over the counter, or Herbal Medications? ☐ - None or Please list Name, Dose, and Frequency.	

Patient's Signature and Date

Anesthesiologist Signature and Date

Physician's Signature and Date

PRE-OPERATIVE

CAPRINI THROMBOSIS RISK FACTOR ASSESSMENT TOOL

Mark all the following statements that apply now or within the past month:

Add 1 point for each of the following statements that apply:

- ☐ Age 41- 60 ____
- ☐ Minor surgery (less than 45 minutes) is planned ____
- ☐ Past major surgery (more than 45 minutes) within the last month. ____
- ☐ Visible varicose veins ____
- ☐ A history of Inflammatory Bowel Disease (IBD) (i.e., Crohn's disease or ulcerative colitis) ____
- ☐ Swollen legs (current) ____
- ☐ Overweight or obese (Body Mass Index above 25) ____
- ☐ Heart attack ____
- ☐ Congestive heart failure ____
- ☐ Serious infection (i.e., Sepsis) ____
- ☐ Lung disease (i.e., Emphysema, COPD, including Pneumonia) ____
- ☐ On bed rest or restricted mobility, including a removable leg brace for less than 72 hours. ____
- ☐ Smoking (Tobacco, Cannabis, E-Cig/Vaping, etc..) ____
- ☐ Diabetes requiring insulin ____
- ☐ Chemotherapy ____
- ☐ Blood transfusions ____
- ☐ Other risk factors (1 point each) ____

For women only:

- ☐ Current use of birth control or Hormone Replacement Therapy ____
- ☐ Pregnant or had a baby within the last month ____
- ☐ History of unexplained stillborn infant recurrent spontaneous abortion (more than 3), premature birth with toxemia, or growth restricted infant. ____

Add 2 points for each of the following statements that apply:

- ☐ Age 61 – 74 ____
- ☐ Current or past malignancies (excluding skin cancer, but not melanoma) ____
- ☐ Planned major surgery lasting longer than 45 minutes ____
- ☐ Laparoscopic and arthroscopic lasting longer than 45 minutes ____
- ☐ Non-removal plaster cast or mold that has kept you from moving your leg within the last month. ____
- ☐ Tube in blood vessel in neck or chest that delivers blood or medicine directly to heart – within the last month (also called central venous access, PICC line, or port) ____
- ☐ Confined to a bed for 72 hours or more. ____

Add 3 Points for each of the following statements that apply

- ☐ Age 75 or older ____
- ☐ History of blood clots, either Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) ____
- ☐ Family history of blood clots (thrombosis) ____
- ☐ Personal or family history of positive blood test indicating as increased risk of blood clotting. ____

Add 5 Points for each of the following statements that apply

- ☐ Elective hip or knee joint replacement surgery. ____
- ☐ Broken hip, pelvis, or leg. ____
- ☐ Serious trauma (i.e., multiple broken bones due to a fall or car accident) ____
- ☐ Spinal cord injury resulting in paralysis ____
- ☐ Experienced a stroke. ____

Add up all points to get total Caprini DVT Risk Score

Risk scores may indicate odds of developing a DVT during major surgery.

Score	Risk Level
0-2	Low
3-8	Increasing
> 8	18.3%

Comments: _____

_____ Patient Signature/Guardian with Relationship

_____ Date

PRE-OPERATIVE

MEDICATION RECONCILIATION LIST

ALLERGIES/MEDICATION SENSITIVITIES WITH REACTION:

MEDICATION, DOSE, & FREQUENCY	USE	LAST TAKEN	MAY RESUME
☐ -NONE			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
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			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

*****MAY RESUME ALL MEDICATIONS UNLESS OTHERWISE NOTED*****

Pre – Op Nurse Signature _____ Date _____ Time _____

Physician Signature _____ Date _____ Time _____

Recovery Nurse Signature _____ Date _____ Time _____

☐ - COPY GIVEN TO PATIENT

-OR-

☐ - N/A

PRE-OPERATIVE

STATE OF CALIFORNIA SURVEY

Dear Patient:

As of January 1, 2019, the State of California, Office of Statewide Health Planning and Development (OSHPD) are required by law that ambulatory surgery centers collect and report individual encounter data (California Health and Safety Code, Division 107 Part 5 – Health Data, Section 128735, 128736, and 128737). The data will be used for health projects, including diagnostic research, identification and correction of disparities in healthcare access and outcomes, management of healthcare delivery and public health programs, quality of care, healthcare trends, and supporting informed decisions. Individually identifiable patient information is protected and encrypted within the State system.

Each patient's **self-reportin**g of their Ethnicity and Race supports integrity and quality of demographics data. A family member or guardian shall complete this information when the patient is not capable.

RACE	**ETHNICITY**
Marl all that apply	Mark only one
❑ - American Indian or Alaska Native ❑ - Asian ❑ - Black or African American ❑ - Native Hawaiian or Other Pacific Islander ❑ - Filipino ❑ - Caucasian ❑ - Other Race: _____	❑ - Hispanic or Latino ❑ - Non Hispanic or Non-Latino

GENDER:
❑ - Male ❑ - Female ❑ - Trans Male/Trans Man ❑ - Trans Female/Trans Woman
❑ - Genderqueer/Gender Nonconforming ❑ - Other Identity:
❑ - Prefer not to disclose

Primary Language Spoken:
❑ - English ❑ - Spanish ❑ - Other: _____

If you have any questions, please contact the Patient Data Section of OSHPD at 916/323-7679. Additional information is available on the internet at www.oshpd.ca.gov/mircal

Thank you very much.

Signature: _____ Date: _____

LEFT SIDE OF CHART

RIVERSIDE OUTPATIENT SURGICAL INSTITUTE

Physician Disclosure of Ownership Statement

Dear Prospective Patient:

We are delighted that you have chosen Riverside Outpatient Surgical Institute, a fully accredited surgical center ("Center") for your elective surgery.

Your treating Physician, and/or Podiatrist ("Physician') has or may have a financial interest in the Center and thus may gain financially by performing your procedure at the Center. You, the patient, have the right to choose where your procedure is performed. By your Physician having a financial interest in this facility it enables them to have a voice in the administration and medical policy of this healthcare institution. This involvement helps to ensure the finest quality of care for our patients. If you have a preference about where your ambulatory procedure is performed other than this Center, please let us know and we will assist you in scheduling such procedure if you wish. Please note that special emphasis is placed on patient feedback so that we can treat you professionally and courteously at all times. Addresses are available upon request.

Due to physician investment in this Center, it is required by law that we notify you of such investment and provide you with alternative facilities available to you.

Parkview Hospital	Riverside Community Hospital	Loma Linda University Medical Center
3865 Jackson Street	4445 Magnolia Avenue	11234 Anderson Street
Riverside, CA 92503	Riverside, CA 92501	Loma Linda, CA 92354
(951) 688-2211	(951) 788-3000	(909) 558-4000

Your signature below will also confirm that you have been made aware of your physician's ownership interest in this Center, and that you have been provided names and address of alternative facilities should you choose to use them.

_____ _____

Patient Signature/Parent of minor child Date

LEFT SIDE OF CHART

Conditions of Coverage and Patient Attestation

Patient Name: _____ **Date of Procedure:** _____

I certify that I have received written documentation of the following items, in advance of the date of my scheduled procedure:

1. Patient Information Form
2. California State Survey
3. Past Medical History Questionnaire
4. Medication Reconciliation List
5. Caprini Risk Assessment
6. Physician Disclosure of Ownership
7. Conditions of Coverage and Patient Attestation
8. Mission Statement
9. Patient's Rights and Responsibilities
10. Advance Directive Information
11. Privacy Practices
12. Patient General Pre-op Instructions
13. Reduce Risk of Infection

Furthermore, I understand that this information is being provided for my benefit and will remain confidential (HIPAA protected). Should I have any questions regarding its content, I should contact the Riverside Outpatient Surgical Institute for clarification.

_____ _____

Patient Signature/Parent of minor child Date

LEFT SIDE OF CHART

4500 Brockton Ave., Suite 105 | Riverside, CA 92501 | 951.784.4088 | Fax 951.784.4089

RIVERSIDE OUTPATIENT SURGICAL INSTITUTE

Mission

Riverside Outpatient Surgical Institute is committed to the care and comfort of our patients and improving the overall health of our community by providing healthcare services with integrity, compassion and excellence.

Vision

Riverside Outpatient Surgical Institute will be known for offering comprehensive outpatient surgical services whose cornerstones are quality, safety, compassion and service excellence.

Values

Passion for Excellence

Strive to consistently exceed patient/customer service expectations.
We value the delivery of compassionate, respectful, high quality of care that promotes optimal outcomes.

Integrity

Demonstrate ethical behaviors at all times.
Guide our actions with honesty and confidentiality.
Keep the best in mind for our patients, staff, physicians, and community.

Dignity

We believe each patient and employee is worthy of respect, and we share the responsibility to safeguard personal dignity.
We care for our patients by recognizing each unique need and striving to meet those needs by considering all issues that affect services.
We believe personal interactions with patients, visitors, physicians and colleagues should be characterized by fairness, compassion and respect.

Teamwork

We will achieve our mission by working together for the health and safety of our patients through the support and use of skills of each team member.
We will maintain timely and effective communication with all team members.

Diversity

Only by understanding our diversities are we able to create an environment where innovation, individuality, and creativity are maintained.
We will respect each other's thoughts, viewpoints, religions, cultural beliefs and back grounds.

Initiative

Build and encourage an environment of trust.
Value and nurture the growth of our most important investment – our people.
We are committed to proactive problem solving.

Community Partner

Embrace every opportunity to strengthen our commitment to the community

Financial Responsibility

Maintain financial integrity to ensure the stability of our Institute.
Ensure a sound financial position through the conscientious management of our Institute.

RIVERSIDE OUTPATIENT SURGICAL INSTITUTE
Notice of Privacy Policies

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction:

At **Riverside Outpatient Surgical Institute (ROSI)** we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 10/01/2014, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record Information

Each time you visit ROSI a record of your visit is made. Typically, the record contains your symptoms, examinations and test results, diagnosis, treatment and a plan for future care or treatment.
This information often referred to as your health or medical record, acts as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of data for medical research.
- A source of information for public health officials charged with improving the health of this state and the nation.
- A source of data for our planning and marketing.
- A tool with which we can asses and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternate means.
- Request a restriction on certain uses and disclosures of your information a provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

ROSI is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternate locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to address you've supplied us, or if you agree, we will email the revised notice to you.

We will not disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For more information or to report a problem

If you have questions and would like additional information, you may contact the Facility's Privacy Officer at (951) 784-4088.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Room 509F, HHH Building
Washington, DC 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
For example: information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. For example: physician services for radiology and certain laboratory tests, or a transcription service we use when dictating your health record and medical billing company. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes, provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

The American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

PATIENT RIGHTS & RESPONSIBILITIES

This accredited facility presents these Patient Rights and Patient Responsibilities to reflect the commitment to providing quality patient care, facilitating dialogue between patients, their physicians, and the facility management, and promoting satisfaction among the patients and their designated support person(s), physicians, and health professionals who collaborate in the provision of care. This facility recognizes that a personal relationship between the physician and the patient is an essential component for the provision of proper medical care. When the medical care is rendered within an organizational structure, the facility itself has a responsibility to the patient to advocate for expanded personal relationships and open communications between patients and their designated support persons, physicians and the organization's staff members. This facility has many functions to perform, including but not limited to, preventing and treating medical conditions, providing education to health professionals and patients, and conducting clinical research. All these activities must be conducted with an overriding concern for the patient and above all the recognition of his or her dignity as a human being. Although no catalogue of rights can provide a guarantee that the patient will receive the kind of treatment he or she has a right to expect, these patient rights are affirmed and actively incorporated into the care provided in this facility.

1. The patient has the right to receive considerate and respectful care in a safe setting.

2. The patient has the right to know the name of the physician responsible for coordinating his/her care.

3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include, but is not limited to his or her diagnosis, treatment, prognosis, and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his or her behalf. When medical alternatives are to be incorporated into the plan of care, the patient has the right to know the name of the person(s) responsible for the procedures and/or treatments.

4. The patient has the right to obtain the necessary information from his or her physician to give informed consent before the start of any procedure and/or treatment. Necessary information includes, but is not limited to, the specific procedure and/or treatment, the probable duration of incapacitation, the medically significant risks involved, and provisions for emergency care.

5. The patient has the right to expect this accredited ambulatory surgery facility will provide evaluation, services and/or referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternatives to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

6. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his or her action.

7. The patient has the right to obtain information about any financial and/or professional relationship that exists between this facility and other health care and educational institutions insofar as his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.

8. The patient has a right to be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in research projects.

9. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not limited to, the following. Confidentiality and discreet conduct during case discussions, consultations, examinations, and treatments. Those not directly involved in his or her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.

10. The patient has the right to expect reasonable continuity of care, including, but not limited to the following. The right to know in advance what appointment times and physicians are available and where. The right to have access to information from his or her physician regarding continuing health care requirements following discharge. The number to call for questions or emergency care

11. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.

12. The patient and designated support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient and guest during all phases of treatment.

13. The patient has the right to be free from all forms of abuse, neglect, or harassment.

14. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.

Patient Responsibilities

It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.

It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed, and ask questions that immerge concerning his or her own health care.

It is the patient's responsibility to provide name of support person in case of emergency, and have this support person available when advised to do so.

Direct any care concerns or complaints to:

The Facility Director: Robert Hardesty, MD
Phone: (951) 784-4088

Director of Clinical Compliance of AAAASF: Ilana Wolff
Phone: (888) 545-5222
Email: info@aaaasf.org

Department of Health: San Bernardino Office
Phone: (909) 388-7170

Office of the Medicare Beneficiary Ombudsman
Phone: (800) 633-4227
Website: http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Advance Directives

On July 1, 2000, the California Health Care Decisions Law went into effect [A.B. 891, 1999 Stat. ch. 658]. The law made extensive changes in the rules governing "advance health care directives," which allow persons to designate how they will be cared for in the event that they later become incompetent. The law revoked existing rules dealing with the designation of surrogates to make health care decision on behalf of incompetent patients, and replaced them with a new set of standards. Thus, the old durable power of attorney for health care statute and the Natural Death Act were repealed. However, documents created under the old laws prior to July 1, 2000 continue to be valid under the same terms on which they were drafted [Cal. Probate Code §4665]. Documents created after July 1, 2000 must conform to the requirements of the California Health Care Decisions Law. In addition, advance directives created in other states under the laws of those states are valid in California [Cal. Probate Code §4676(a)].

The California Health Care Decisions Law identifies two types of advance directives that a competent adult may sign to deal with future situations where he or she may be incompetent. The first is an "individual health care instruction," by which a person states his or her wishes concerning treatment or non-treatment in particular named circumstances, including, possibly, end-of-life situations. The second is a "power of attorney," by which an individual designates an "agent" to make decisions on his or her behalf in the event of incompetency. The California Health Care Decisions Law presents a model form entitled "Advance Health Care Directive" that serves as both a power of attorney and an individual health care instruction [Cal. Probate Code §4701].

An Advance Health Care Directive is the best way to make sure that your health care wishes are known and considered if for any reason you are unable to speak for yourself. By completing a form called an "Advance Health Care Directive" California law allows you to do either or both of two things:

First, you may appoint another person to be your health care "agent." This person (who may also be known as your "attorney-in-fact") will have legal authority to make decisions about your medical care if you become unable to make these decisions for yourself. Second, you may write down your health care wishes in the Advance Health Care Directive form-for example, a desire not to receive treatment that only prolongs the dying process if you are terminally ill.

The Advance Health Care Directive is now the legally recognized format for a living will in California. It replaces the Natural Death Act Declaration. The Advance Health Care Directive allows you to do more than the tradition living will, which only states your desire not to receive life-sustaining treatment if you are terminally ill or permanently unconscious. An Advance Health Care Directive allows you to state your wishes about refusing or accepting life-sustaining treatment in any situation.

Unlike a living will, an Advance Health Care Directive also can be used to state your desires about your health care in any situation in which you are unable to make your own decisions, not just when you are in a coma or are terminally ill. In addition, an Advance Health Care Directive allows you to appoint someone you trust to speak for you when you are incapacitated. You do not need a separate living will if you have already stated your wishes about life-sustaining treatment in an Advance Health Care Directive.

The Advance Health Care Directive has replaced the Durable Power of Attorney for Health Care (or "DPAHC") as the legally recognized document for appointing a health care agent in California. The Advance Health Care Directive allows you to do more than a DPAHC. An Advance Health Care Directive permits you not only to appoint an agent, but to give instructions about your own health care. You can now do either or both of these things.

Our Policy: While all of these documents play a very important role as to how health care decision are made on your behalf, it is the policy of **RIVERSIDE OUTPATIENT SURGICAL INSTITUTE** that we **DO NOT** honor Advance Directives during your episode of care at the facility. If you have an Advance Directive, please bring it with you for your visit to **RIVERSIDE OUTPATIENT SURGICAL INSTITUTE** and we will place it in your medical record for reference in the unlikely event you are transferred to the hospital.

Addition information and resources, including sample forms, are available from the website of the Office of the Attorney General: http:ag.ca.gov/consumers/general/adv_hc_dir.htm. We can also provide you with a sample Advance Health Care Directive form upon your request.

PATIENT GENERAL PRE-OP INSTRUCTIONS

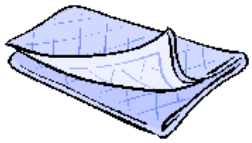
1. Nothing to eat or drink 8 hours prior to your surgery (Medications, only take your **high blood pressure**, **cardiac** or **thyroid meds** with a **very small sip** of water in the morning.)
2. Leave all valuables at home (you will be provided a locker).
3. Wear loose fitting comfortable clothes (button up or zipper shirt/blouse).
4. No makeup, lotion, moisturizers, deodorant, or false eyelashes.
5. Remove all external rings or piercings if possible.
6. Make out a list of any questions you may have for the nurse, doctor or anesthesia.
7. If you are a diabetic and you take insulin do not take in the morning, please bring your insulin with you just in case you need to be medicated after surgery.
8. You will be called a few days up to the day before surgery to confirm your exact time of arrival. If you don't receive a call from us, please call us at (951) 784-4088.
9. Your anesthesia provider will also contact you usually the night before just to go over any health or anesthesia concerns.
10. The evening before and the morning of, shower and use an antimicrobial soap such as Dial over all surgical areas.
11. You will need an adult caregiver to pick up, transport you to your home and be with you for twenty four (24) hrs. Uber and taxis are not acceptable.

4500 Brockton Ave., Suite 105 | Riverside, CA 92501 | 951.784.4088 | Fax 951.784.4089

REDUCE YOUR RISK OF INFECTION

Site Preparation

Follow your doctor's instructions to shower or cleanse your surgical site before arriving for your surgery to remove bacteria from your skin. If there are no instructions, please bathe or shower before coming. You should not shave the area where you are having surgery.



Warmth

Studies have shown that keeping warm during and after your surgery may improve outcomes. Please let your nurse know if you are cold so that we can perform warming measures.

Hand Hygiene

Hand hygiene is the most effective way of preventing the spread of infection. Please ask a healthcare staff if they have washed their hands or used an alcohol hand rub. As a patient you should also practice good hand washing after using the bathroom, before eating, after blowing your nose and before and after touching the bandage or your incision.

Smoking Cessation

If you are a smoker, consider quitting. This will reduce your chances of developing an infection after surgery.

Please let your doctor and anesthesiologist know if you are a diabetic so that we can manage your blood sugar during your stay at ROSI.