



## Pre-Operative Adult Information Packet

Thank you for choosing Augusta ENT for your healthcare needs. You will be scheduled for surgery at the ENT Surgery Center of Augusta located at the back of our Evans office.

### Arrival Time

You will receive a phone call the work day before your surgery day telling you the time you need to arrive at the surgery center. Example: If your surgery is on Monday, you would receive a call the Friday before. Please write the arrival time at the top of this page.

Surgery Date \_\_\_\_\_

Arrival Time \_\_\_\_\_

ENT Surgery Center of Augusta  
340 N Belair Rd  
Evans, GA

706-868-5676

### Eating and Drinking Rules

In addition to the Eating and Drinking Rules page in this packet you will be given instructions over the phone about eating and drinking the day before your surgery.

### Billing Information

You can expect to receive up to 4 bills for your surgery:

1. Facility From The ENT Surgery Center of Augusta
2. Doctor From the physician that performed the surgery
3. Anesthesia From the anesthesiologist that put you to sleep
4. Pathology If specimens were obtained during surgery, your doctor will inform you and/or your family member after the procedure if specimens were sent to the lab.

It is the policy of this center to collect co-pays and/or deductibles prior to or on the day of surgery. You should receive a call from our business office if there will be any payment due prior to your surgery.

Billing questions please call (706) 868-5676 ext. 738 or ext. 659.

Surgical questions please call (706) 868-5676 ext. 756

Please fill out, sign, and bring the following forms with you on the day of your surgery:

1. Lab Release Form – Contact your insurance carrier or your caseworker to find out which lab is in your insurance plans network. This is to avoid sending specimens an out of network lab which will cause out-of-pocket expenses for you.
2. Pre-op Instructions
3. Medication Reconciliation Form
4. Anesthesia History & Physical
5. Patient Consent to the Use and Disclosure of Health Information

# Notification

## **PATIENT RIGHTS**

The ENT Surgery Center would like to assure you of your rights and responsibilities as a patient.

You have a right to:

- Considerate, respectful & dignified care provided in a safe environment, free from all forms of abuse, neglect harassment and/or exploitation.
- Personal and informational privacy, within the law.
- Information concerning your diagnosis, treatment & prognosis, to the degree known in a language or manner you understand, or to an individual designated by you or to a legally authorized individual as part of the informed consent process.
- Appropriate assessment and management of pain.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns of your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Know and inquire about the identity & professional status of individuals providing service.
- Request a change in providers of care if other qualified providers are available.

## **HEALTHCARE PRACTITIONERS IN THIS FACILITY**

This surgery center employs Medical Doctors, Doctors of Osteopathy, Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Certified Surgical Technicians, Surgical Technicians and Operating Room Technicians.

## **PATIENT COMPLAINT OR GRIEVANCE**

The ENT Surgery Center will promptly review, investigate & resolve any patient grievances or complaints in a timely manner. If you feel you may have an issue, we provide you with the following contact information:

ENT Surgery Center of Augusta  
340 North Belair Rd, Evans, GA 30809 Attention: Keith Lynn, Administrator  
(Within 20 working days you will receive written notice of the status of your grievance from Mr. Lynn.)

Georgia Dept. of Community Health  
ATTN: Complaints Dept  
2 Peachtree Street, Suite 3100  
Atlanta, GA 30303-3142  
404-657-5726  
1-800-878-6442  
<http://ors.dhr.georgia.gov/portal/site/DHR-ORS>

All Medicare patients may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's web page at: <http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html> 1-800-MED-ICARE

## **CONSULTATION**

The patient, at his/her own request and expense, has the right to consult with a specialist.

## **PATIENT RESPONSIBILITIES**

You are responsible for:

- Providing accurate complete information regarding your present health status (including past and present prescription, herbal, over the counter and supplement medications), past medical history, & for reporting any unexpected changes to the appropriate practitioner (s).
- Following the treatment plan recommended by the primary practitioner.
- Following the rules & regulations of the facility affecting patient care & conduct.
- In the case of a pediatric patient, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
- Be considerate & respectful of the rights of other patients & facility personnel.
- Providing a responsible adult to transport you home after surgery & an adult to be responsible for you at home for the first 24 hours after surgery/anesthesia.
- Indicating whether you clearly understand a contemplated course of action & what is expected of you.
- Your actions if you refuse treatment, leave the facility against the advice of the practitioner and/or do not follow the practitioner's instructions relating to care.
- Assuring financial obligations of your health care are fulfilled as expediently as possible.

## **PRIVACY AND CONFIDENTIALITY**

The ENT Surgery Center of Augusta complies with federal HIPAA (Health Insurance Portability & Accountability Act) regulations to maintain the privacy of your health information.

## **ADVANCE DIRECTIVES AND LIMITATIONS**

The ENT Surgery Center of Augusta is not an acute care facility; therefore it is our policy to honor an advance directive with the exception of the Do Not Resuscitate (DNR) portion of the advance directive as permitted by Georgia State Statutory law [O.C.G.A. § 31-32-8(2) and O.C.G.A. § 31-32-9(d) (1-2)]. We will adhere to this policy that any physician performing any type of procedure at the Center should not effectuate the DNR order portion of an advance directive. Appropriate emergency procedures will be undertaken to resuscitate patients and transfer them to appropriate facilities in the event of deterioration. Your agreement with this policy **does not** revoke or invalidate any current health care directives or health care power of attorney. If you have an Advance Directive, it is your responsibility to provide a copy to our center on the day of your procedure. Should you be taken to the hospital your copy will go with you. If you would like an Advance Directive you may request one from the front desk of the surgery center.

## **DISCLOSURE OF OWNERSHIP**

The ENT Surgery Center of Augusta is an LLC, owned wholly by the physicians of Augusta ENT, PC, under Georgia State law as a single specialty ambulatory surgery center, Permit 036-286. The physician owners are Drs. Ayers, Barfield, Deal, Kimbrough, Lindman, Owen, Porubsky, Rutledge, Vickery, White, and Whitehouse.

## Pre-Op Instructions

Failure to follow these instructions will result in the cancellation of your surgery:

If you have any questions feel free to call our office at 706-868-5676.

- \_\_\_\_\_ 1. Make arrangements to have a responsible adult with you to drive you home after surgery. You must have an adult stay with you for the first 24 hours after your surgery. A parent or legal guardian must accompany a minor.
- \_\_\_\_\_ 2. A nurse from the surgery center will contact you the work day before your surgery with your arrival time. For the safety of our employees, the door of the surgery center will not be unlocked until 6:30 am. Due to limited space, please limit family to two (2) people.
- \_\_\_\_\_ 3. Do not eat anything (not even candy, gum, or mints) for at least eight (8) hours before your arrival time at the surgery center. You may have clear liquids (water, apple juice, Gatorade/pedialyte, tea or black coffee) up to three (3) hours before your scheduled time of arrival.
- \_\_\_\_\_ 4. If you routinely take prescription medications, you may do so until three (3) hours prior to your arrival time, unless you have been directed otherwise by your surgeon or anesthesiologist.
- \_\_\_\_\_ 5. Do not wear any make-up, nail polish, hairpins or jewelry to the surgery center. Do not bring money or valuables.
- \_\_\_\_\_ 6. Shower or bathe the night before or the morning of surgery. Do not use lotions or oils on the skin the night before or the morning of surgery. Deodorant is permitted.
- \_\_\_\_\_ 7. Notify the surgeon of any change in your physical condition (fever, cold, sore throat, etc.) before the surgery.
- \_\_\_\_\_ 8. Wear loose comfortable clothing and shoes that slip on easily. No jeans, pantyhose, high heels or boots.
- \_\_\_\_\_ 9. Do not wear contact lenses.
- \_\_\_\_\_ 10. Please do not take any aspirin products (Advil, Motrin, Aleve, Goody powders, etc.) as well as herbs and vitamins two (2) weeks prior to your surgery date.
- \_\_\_\_\_ 11. An anesthesiologist will talk to you on the day of your surgery and answer any questions you may have regarding anesthesia.
- \_\_\_\_\_ 12. Please bring a bottle or sippy cup for infants or small children for use after surgery.
- \_\_\_\_\_ 13. Please call your insurance company to find out the laboratory they use and please bring your insurance card with you on the day of surgery.

\_\_\_\_\_  
SIGNATURE OF PATIENT/ LEGAL GUARDIAN

\_\_\_\_\_  
DATE / TIME

\_\_\_\_\_  
Signature of Nurse

\_\_\_\_\_  
DATE / TIME

# Medication Reconciliation Form

Allergies: No Known Allergies See Attached list for extensive allergies Allergy/Reaction 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____	Patient Label
Medication Information Obtained From: <input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Written List	

<b>Current Home Medication List</b> To be completed by Patient pre-operatively (Including: Prescriptions, Over the counter, Herbal Remedies, Vitamins, Dietary Supplements)	To be Completed by Physician on day of Surgery
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Medication	Reason	Dose	Route:Oral, Injection, Patch, Drops	Frequency	Last doseDate/Time	Continue After Discharge		Check with Prescribing Physician
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>
						<input type="checkbox"/> YES	<input type="checkbox"/> No Resume On _____	<input type="checkbox"/>

Patient Acknowledgement:  
 I have provided as accurate a list as I can of my home medications. I will continue to follow the medication order of the prescribing physician unless instructed to change. If I have any questions about my home medications, I will call the doctor prescribing them.

Patient (Designee) Signature \_\_\_\_\_ Date \_\_\_\_\_

New/Changed Medications to be taken upon discharge:  N/A

Medication	Dose	Frequency	Route	Other Instructions

Admission	Discharge				
<input type="checkbox"/> List reviewed with patient	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;">RN Signature</td> <td style="width: 25%; border: none;">Date/Time</td> <td style="width: 25%; border: none;">Responsible Party</td> <td style="width: 25%; border: none;">Date/Time</td> </tr> </table>	RN Signature	Date/Time	Responsible Party	Date/Time
RN Signature	Date/Time	Responsible Party	Date/Time		
RN Signature _____ Date/Time _____	Physician Signature _____ Date/Time _____				

## Lab Release Form

Patient Name: \_\_\_\_\_

Surgery Date: \_\_\_\_\_

ENT Surgery Center of Augusta uses Piedmont Hospital for specimens and blood work. If this lab does not in network with your insurance please check the lab of your choice at the bottom of this form and your labs will be sent there.

If you fail to choose a specific lab, your laboratory test will be sent to Piedmont Hospital.

### Payment Policy

I understand that it is my responsibility to inform the ENT Surgery Center of Augusta of the lab that my insurance company covers. I also understand that I am personally responsible for payment of all charges, which are incurred for services rendered to me or the above name regardless of insurance coverage.

Select ALL labs within your insurance network:

- Piedmont Hospital Lab
- Quest
- Doctors Hospital
- Lab Corp
- Clinical Laboratories Southeast.

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SIGNATURE OF PATIENT/ LEGAL GUARDIAN

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DATE / TIME

# Anesthesia History and Physical

HOME PHONE: \_\_\_\_\_

Patient Label

ALTERNATIVE #: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ AGE: \_\_\_\_\_

RACE:  American Indian  Asia  Black  Hispanic  Pacific Islander  White  Multi-Racial

TYPE OF SCHEDULED PROCEDURE: \_\_\_\_\_ DATE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_

WHO WILL BE WITH YOU THE DAY OF SURGERY: \_\_\_\_\_

LIST ALL SURGERIES AND DATES:

Date	Surgery
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_____	_____
_____	_____
_____	_____
_____	_____

DATE OF LAST EKG: \_\_\_\_\_

NORMAL

ABNORMAL

NAME OF YOUR FAMILY PHYSICIAN: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

\* Requested by State of Georgia Department of Community Health

PLEASE CHECK ONE OF THE FOLLOWING: (PATIENT INFORMATION ONLY)

YES NO

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Any problems with prior anesthetics?<br>If yes, please describe: _____                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever had fever after an anesthetic?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has any family member had problems with anesthetics, including malignant hyperthermia, paralysis, etc.? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you smoke?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you drink alcohol?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you use any recreation drugs, including heroin, cocaine, marijuana, etc?                             |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you allergic to latex?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you taken steroids over the past year?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Can you climb 2 flights of stairs nonstop without getting chest pain or shortness of breath?            |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you exercise?<br>Type/how often? _____  |

# Anesthesia History and Physical

- 11. Have you ever had a blood transfusion?  
If yes, when? \_\_\_\_\_
- 12. Could you be pregnant?  
What is the date of your last menstrual period? \_\_\_\_\_
- 13. Do you have any bleeding or clotting abnormalities including easy bruising or excessive vaginal bleeding?
- 14. Do you have any implants?  
If yes, what type? \_\_\_\_\_
- 15. Have you had any recent colds?  
If yes, when? \_\_\_\_\_
- 16. Do you have loose teeth, chipped teeth, dentures, caps, crowns, bridgework, braces?  
If yes, please list. \_\_
- 17. Do you have difficulty or pain with opening your mouth widely or tilting your head back to look above you
- 18. Do you wear contact lenses or glasses?
- 19. Do you go to a pain management clinic? If so who is your doctor and what is your reason for going?  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following:

- 1. Thyroid or goiter problems?
- 2. Diabetes or epilepsy?
- 3. Muscle weakness, paralysis, stroke?
- 4. High blood pressure?
- 5. Chest pain, angina?
- 6. Heart disease, murmur, mitral valve prolapse?
- 7. Lung disease, shortness of breath, chronic cough?
- 8. Asthma, wheezing? Last attack:
- 9. Kidney or bladder disease?
- 10. Hepatitis, jaundice, cirrhosis, HIV positive?
- 11. Ulcers?
- 12. Hiatal hernia or reflux?
- 13. Anemia or recent weight loss?
- 14. Have you ever had nose or jaw surgery?
- 15. Have you had any broken facial bones?
- 16. Frequent headaches or dizzy spells?
- 17. Any back problems, including surgeries, fractures, painful positions.
- 18. Motion sickness?
- 19. Have you ever taken Redux, Phen-Phen, or any other diet pill? Date\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PATIENT/ LEGAL GUARDIAN

Assessment reviewed, positive findings were discussed with patient/family.

\_\_\_\_\_  
DATE / TIME

\_\_\_\_\_  
ANESTHESIOLOGIST'S SIGNATURE

\_\_\_\_\_  
DATE / TIME

Patient Consent to the Use and Disclosure of Health Information  
For Treatment, Payment, or Healthcare Operations

I, \_\_\_\_\_, understand that as part of my health care, **ENT Surgery Center of Augusta, LLC** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand and have been provided with a *Notice of Privacy Policies* that provides a complete description of information uses and disclosures in addition to my rights. I understand that **ENT Surgery Center of Augusta, LLC** is not required to agree to any restrictions requested by me. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that **ENT Surgery Center of Augusta, LLC** reserves any right to change their notice in accordance with Section 164.520 of the Code of Federal Regulations. Should **ENT Surgery Center of Augusta, LLC** change their notice an updated copy will be available upon my next visit to the practice and/or I may request a copy be sent to my address. I also may visit the office at any time to obtain a current copy of the practice's Notice.

I wish to have the following restrictions to the use or disclosure of my health information: \_\_\_\_\_  
\_\_\_\_\_

I wish to allow the following individuals access to my medical records, medical information, billing and payment information with ENT Surgery Center of Augusta, LLC: \_\_\_\_\_  
\_\_\_\_\_

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

**\*Please initial by each form of communication by which we can contact the patient.\***

\_\_\_\_\_ ENT Surgery Center of Augusta, LLC may **call** my home at the following number and leave the appointment date and time on my telephone answering machine, voicemail, or with whomever answers my phone if I am not available. I understand that other individuals may have access to the information left by this method. I understand that no other information will be provided in granting permission to leave the date and time.

**Telephone Number on which messages can be left:** \_\_\_\_\_

\_\_\_\_\_ ENT Surgery Center of Augusta, LLC may **email** my home or other email address any information that will assist ENT Surgery Center of Augusta with the treatment, payment, and health care operations for the patient. This can include appointment reminders, statements, insurance information, and any information concerning my clinical care.

**Email address to which information can be sent:** \_\_\_\_\_

\_\_\_\_\_ ENT Surgery Center of Augusta, LLC may send a **text message** to my cellular phone regarding appointment reminders, cancellations, or time changes. This form of communication will be for the use of the Appointment Desk and not private or clinical information.

**Cell Phone to which information may be texted:** \_\_\_\_\_

\*\*\* I fully understand and (circle one) **[accept / decline]** the terms of this consent. \*\*\*

_____	_____	_____	_____
SIGNATURE OF PATIENT/ LEGAL GUARDIAN	Date	Practice Representative	Date

FOR OFFICE USE ONLY

[ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_ [ ]  
Consent refused by patient, and treatment refused as permitted. \_\_\_\_\_ [ ]  
Notice provided to patient. Consent form not signed due to: \_\_\_\_\_  
Action to be taken: \_\_\_\_\_



# Eating and Drinking

## Eating or drinking rules before your surgery or procedure

Food and drink taken before anesthesia can cause problems such as choking or vomiting. There are a few rules about eating and drinking that can prevent these problems.

1. Until Midnight:

You may eat and drink up until Midnight before your surgery or procedure

2. After Midnight:

After Midnight on the night before your surgery or procedure you may only have liquids you can see through:

Examples:

- water
- apple juice
- other clear juices
- plain jello
- tea
- black coffee

No juice with pulp

No milk or carbonated drinks

3. Three (3) hours before arrival time:

You may not have anything three (3) hours before your arrival time.

You will receive more specific eating and drinking instructions, as well as, instructions regarding taking your usual prescribed medications from our preoperative nurse the day before your surgery.

Call if you have any Surgical questions please call  
(706) 868-5676 ext. 756, 757 or ask for the Surgery Center Pre-Op Department  
Monday - Friday  
9 am - 4:30 pm

## Statement of Nondiscrimination

The ENT Surgery Center of Augusta complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The ENT Surgery Center of Augusta does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The ENT Surgery Center of Augusta provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

The ENT Surgery Center of Augusta also provide free aids and services to help people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats and more)

If you need these services for your surgical procedure, please tell the nurse during your preoperative interview or call 706-364-4040.

If you believe that the ENT Surgery Center of Augusta has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Keith Lynn  
Civil Rights Coordinator  
340 N. Belair Rd  
Evans, GA 30809  
Phone: 706-868-5676  
Fax: 706-922-4385

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, a patient representative will help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

Centralized Case Management Operations  
U.S. Department of Health and Human  
Services 200 Independence Ave. SW  
Room 509F, HHH  
Building Washington,  
D.C. 20201

**1-800-368-1019**

**1-800-537-7697 (TDD)**

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

