AUGUSTA ENT
ear • nose • throat

Pre-Operative Information Packet

Surgery Date _____

Arrival Time _____

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

706-868-5676

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.

Pre-Operative Testing

You may require an EKG and possibly some routine blood test before your surgery. If you have not seen your primary care physician recently (within the year), please contact our pre-operative department at the number provided below.

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.

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.

_____ _____

Signature of Patient/ Legal Guardian Date / Time

Pre-Op Instructions

Failure to follow the 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) after midnight the night before your surgery.

_____ 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:

☐ Patient ☐ Family ☐ Written List

Current Home Medication List

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

Medication	Reason	Dose	Route:Oral, Injection, Patch, Drops	Frequency	Last doseDate/Time	Continue After Discharge		Check with Prescribing Physician
						☐ YES	☐ No Resume On ______	☐
						☐ YES	☐ No Resume On ______	☐
						☐ YES	☐ No Resume On ______	☐
						☐ YES	☐ No Resume On ______	☐
						☐ YES	☐ No Resume On ______	☐
						☐ YES	☐ No Resume On ______	☐
						☐ YES	☐ No Resume On ______	☐
						☐ YES	☐ No Resume On ______	☐
						☐ YES	☐ No Resume On ______	☐
						☐ YES	☐ No Resume On ______	☐

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			
☐ List reviewed with patient				
	RN Signature	Date/Time	Responsible Party	Date/Time
RN Signature Date/Time	Physician Signature	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

ALLERGIES: _____

TYPE OF REACTION: _____

TYPE OF SCHEDULED PROCEDURE: _____ DATE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE #: _____

WHO WILL BE WITH YOU THE DAY OF SURGERY: _____

LIST ALL MEDICATIONS AND STRENGTHS YOU TAKE DAILY:

(INCLUDE EYE DROPS, INHALERS, VITAMINS, HERBAL SUPPLEMENTS, ASPRIN, BIRTH CONTROL PILLS)

DRUG AND STRENGTH LAST TAKEN REASON FOR TAKING

_____

_____

_____

_____

_____

_____

LIST ALL SURGERIES AND DATES:

Date Surgery

_____

_____

_____

_____

_____

* REQUESTED BY STATE OF GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Anesthesia History and Physical

ARE YOU CURRENTLY EXPERIENCING ANY PAIN ____ YES _____NO
IF YES PLEASE DESCRIBE:

_____

_____

DATE OF LAST X-RAY: _____ ☐ NORMAL ☐ ABNORMAL
DATE OF LAST EKG: _____ ☐ NORMAL ☐ ABNORMAL
NAME OF YOUR FAMILY PHYSICIAN: _____TELEPHONE # _____

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

YES	NO		
☐	☐	1.	Any problems with prior anesthetics? If yes, please describe: _____
☐	☐	2.	Have you ever had fever after an anesthetic?
☐	☐	3.	Has any family member had problems with anesthetics, including malignant hyperthermia, paralysis, etc.?
☐	☐	4.	Do you smoke?
☐	☐	5.	Do you drink alcohol?
☐	☐	6.	Do you use any recreation drugs, including heroin, cocaine, marijuana, etc?
☐	☐	7.	Are you allergic to latex?
☐	☐	8.	Have you taken steroids over the past year?
☐	☐	9.	Can you climb 2 flights of stairs nonstop without getting chest pain or shortness of breath?
☐	☐	10.	Do you exercise? Type/how often? _____
☐	☐	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?

_____

_____

Anesthesia History and Physical

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 DATE / TIME

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

_____ _____

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: _____

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.

Statements of Nondiscrimination in Languages Used in Georgia

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 706-364-4040.

Spanish
ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de interpretación. Comuníquese con alguien del personal de registros o llame al 706-364-4040.

Vietnamese
CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin liên lạc với nhân viên phụ trách ghi danh hay gọi số 706-364-4040.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 706-364-4040 번으로 전화해 주십시오.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 706-364-4040

Gujarati
ચના: જો તમે જરાતી બોલતા હો, તો ન: લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 706-364-4040

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 706-364-4040

Amharic
ማሳ ሳ ሰ ቢያ -አ ማር ኛ ተና ጋ ሪ ከ ሆኑ ፤ ነ ፃ የ ሆነ የ ቋን ቋ ዕ ገ ዛ አ ገ ልግሎቶች ለ እ ር ስ ዎ ተዘ ጋ ጅተዋል፡ ፡
ከ ምዝገ ባ ሰ ራተኞች ውስ ጥ አ ን ዳ ቸውን ያ ነ ጋ ግሩ ወይም በ ስ ልክ ቁጥር 706-364-4040 ይደውሉ፡ ፡

Hindi
ध्यान दें: यदद आप हिंदी बोलते तो आपके ललए मुफ्त में भाषा सिं यता सेवाएं उपलब्ध ह। 706-364-4040 पर फोन करें।

French Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 706-364-4040

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 706-364-4040

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
هاتف الصم والبكم: 706-364-4040

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 706-364-4040

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 706-364-4040 تماس بگیرید.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich an das Anmeldungspersonal oder wählen Sie die Rufnummer 706-364-4040

Japanese
注意事項：日本語での言語サポートを無料で提供しています。レジストレーシ ョン・スタッフ、または 706-364-4040 までお問い合わせください。