



Generalized Instructions for patients of the Outpatient Surgery Center of St. Augustine

1. Please complete as much of the following forms prior to coming to the Surgery Center for your Pre-Op appointment. You can either bring them with you for your Pre-Op appointment or you can fax the paperwork to (904) 209-1401. If you have any questions please call (904) 209-1400.
2. Remember that you **MUST** arrange for transportation and someone to stay with you after your procedure. We cannot allow patients who have received anesthesia to go home with COA or in a taxi unaccompanied.
3. Ask your Primary Care Physician and/or Cardiologist to send clearances and test results as quickly as possible to the Surgery Center. Our fax number is (904) 209-1402.
4. Please have friends and family members bring a jacket or light sweater. The waiting area tends to be cool.
5. If you are receiving general anesthesia and use a BIPAP or CPAP machine. Please bring your machine with you on the day of surgery.
6. Our phone number is (904) 209-1400. Our hours of operation are Monday – Friday from 6:00 AM – 5:00PM.

OUTPATIENT SURGERY CENTER OF ST. AUGUSTINE, LLC

Health Care Advance Directives

When a person becomes unable to make decisions due to physical or mental change, such as being in a coma, they are considered incapacitated. To ensure that an incapacitated person's decisions about health care will be respected, the Florida legislature enacted legislation pertaining to health care advanced directives (Chapter 765, Florida Statutes).

An advance directive is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some persons make advance directives when they are diagnosed with a life-threatening illness, while others put their wishes into writing while they are healthy, often as part of their estate planning. Types of advance directives include: 1) A Living Will, 2) A Health Care Surrogate Designation, and 3) An Anatomical Donation.

Outpatient Surgery Center of St. Augustine does not honor advance directives, however we would like to be notified should you have one in place. Should you wish to obtain more information about advance directives, you may contact www.aarp.org or www.FloridaHealthFinder.gov (888-419-3456).

Disclosure of Ownership

Outpatient Surgery Center of St. Augustine, LLC is a joint venture between Flagler Hospital and several area physicians who have chosen to treat their patients at a facility, where as an owner, they have more input into the quality of care provided to their patients.

Physician Investors include:

Albert Volk, M.D.	James Grimes, M.D.	Kurtis Hort, M.D.
Brian Haycock, M.D.	John Stark, M.D.	Beth Pearce, DPM

Patient Rights

Medicare patients desiring additional information regarding patient rights should contact the Medicare Ombudsman at www.cms.hhs.gov/center/ombudsman.asp .

Patient Acknowledgement

I have reviewed the information provided regarding the Patient Bill of Rights and Responsibilities, Advance Directives, and Disclosure of Ownership and any questions have been answered to my satisfaction.

___ I have an Advance Directive and I am aware of the policy of the surgery center

___ I do not have an Advance Directive and I am aware of the policy of the surgery center

Patient Signature

Date Received

OUTPATIENT SURGERY CENTER OF ST. AUGUSTINE, LLC

Information for Our Patients Concerning Surgery Billing

Dear Patient,

Thank you for choosing the Outpatient Surgery Center of St. Augustine for your procedure. This facility works with many qualified health care professionals and services to provide coverage for all aspects of your surgical experience. These include physician professional services, anesthesia services, pathology services, and fluoroscopy services.

We would like to provide you with information regarding the bills you and your insurance company may receive for the services provided at our center. They may include the following:

- ◆ **Physician Professional Services.** You will receive a bill from Orthopaedic Associates of St. Augustine or Dr. Dew's office (phone numbers listed below).
- ◆ **Facility Fee.** This bill is generated from the Outpatient Surgery Center of St. Augustine and is inclusive of pre-operative care, operating room charges to include all supplies and medications, implants which may be required for your particular procedure, and recovery room charges.
- ◆ **Anesthesia Services.** Jacksonville Anesthesia Corporation provides anesthesia services for the facility and will bill your insurance for care provided by the anesthesiologist and/or nurse anesthetist.
- ◆ **Pathology.** Should it be necessary to send a specimen for evaluation, you will receive a bill for this service from either Pantaleon Pathology Group or the pathology lab specified by your insurance plan.
- ◆ **Fluoroscopy Services.** Should fluoroscopy services be required during your procedure, this charge will be billed to your insurance plan by Palm Beach Fluoroscopy Services.

We realize that this paperwork on occasion becomes complicated and we would like to provide assistance with any concerns you may have. Please contact the correct office so they can assist you properly:

Outpatient Surgery Center of St. Augustine: (904)209-1400

Orthopaedic Associates of St. Augustine: (904) 825-0540

Dr. Dew: (386)328-9686

Dr. Pippins: (904)398-3356

Jacksonville Anesthesia c/o Pro-Medical Inc.: (800)-237-6723

Pathology: (904)824-9299

Fluoroscopy Service: (561)630-6277 or (888) 855-5852/ Fax- (561)578-8281

Thank you,

Outpatient Surgery Center of St. Augustine

**DISCHARGE AND WAIVER
OF OUTPATIENT SURGERY CENTER OF ST. AUGUSTINE, LLC
("FACILITY")**

I, _____, hereby agree and
(Name of patient/Patient representative)

Acknowledge as follows:

1. I have chosen FACILITY to perform an Outpatient Procedure. As indicated below, I understand that the FACILITY has contracted with entities/physicians and their staff and employees to provide certain services to me. I further understand that the entity's/physician's staff or employees may include, but are not limited to, physicians, physician's assistants (P.A.), advanced registered nurse practitioners (ARNP), certified registered nurse anesthetists (CRNA), registered nurses (RN), licensed practical nurses (LPN), medical students, or therapeutic radiological physicists (hereinafter "Staff").

(a) ANESTHESIA SERVICES

FACILITY has contracted with Jacksonville Anesthesia Corporation, Inc. to provide anesthesia services to you. Jacksonville Anesthesia Corporation, Inc. is an independent contractor of FACILITY and FACILITY does not have any control over the work performed by Jacksonville Anesthesia Corporation, Inc. or its staff.

2. Your physician, Dr. _____, is not an employee of the FACILITY; therefore the services provided by FACILITY do not include the services provided by Dr. _____ or his/her staff.
3. FACILITY does not employ any physicians, osteopathic physicians, doctors of podiatric medicine, doctors of chiropractic medicine, physician's assistants (P.A.) advanced registered nurse practitioners (ARNP), certified registered nurse anesthetists (CRNA), or medical students. If any such persons or entities provide care to me as a result of my treatment at FACILITY, including but not limited to Dr. _____, I understand that that person or entity is an independent contractor, and not an employee, of FACILITY.
4. To the extent that the FACILITY is obligated by contract, statute, regulation or common law to provide any services other than that of nursing services, FACILITY has delegated those services to independent contractors.
5. I discharge FACILITY of any and all contractual, statutory, regulatory, or common law duties, regardless of whether said duties are delegable or non-delegable, to provide services to me other than nursing services.

6. Acknowledgement: I acknowledge that I have read this Discharge and Waiver in its entirety and understand all of its provisions. To the extent that I did not understand any provisions, I acknowledge that the FACILITY provided me with the opportunity to ask questions and that the FACILITY answered questions to my satisfaction.

PATIENT/PATIENT'S REPRESENTATIVE

BY: _____
Patient or Patient's Representative Signature

Print Patient Name or Representative Name

Date: _____

WITNESS:

By: _____

Print Name of Witness

Date: _____

PATIENT INFORMATION
FILL OUT ENTIRELY

PATIENT'S NAME: _____ DATE OF SURGERY: ____/____/____

SOCIAL SECURITY #: _____ DATE OF BIRTH: ____/____/____ SEX: MALE/FEMALE

ADDRESS: _____ CITY: _____

STATE _____ ZIP _____

PHONE #: _____ CELLULAR _____ WORK _____

EMERGENCY CONTACT/RELATIONSHIP _____ PH. NO. _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

LIVING WILL/ADVANCED DIRECTIVE: YES NO STUDENT: YES NO

IS THIS A RESULT OF AN ACCIDENT? YES NO DO YOU HAVE AN ATTORNEY? YES NO

IF ANSWERED YES, PLEASE LIST ATTORNEY INFORMATION: _____

EMPLOYMENT STATUS: *FULL TIME PART TIME RETIRED DISABLED NOT EMPLOYED*

RACE: WHITE BLACK ASIAN/PACIFIC ISLANDER

WHITE HISPANIC BLACK HISPANIC OTHER

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

◇ PRIMARY INSURANCE: _____
NAME/DATE OF BIRTH (if different than self): _____
POLICY #: _____

◇ SECONDARY INSURANCE: _____
NAME/DATE OF BIRTH: (if different than self) _____
POLICY #: _____

WORKERS COMP ONLY	
EMPLOYER: _____	PHONE #: _____
ADDRESS: _____	
DATE OF INJURY: ____/____/____	W/C CARRIER: _____

SIGNATURE: _____ DATE: ____/____/____

PRE-OP INSTRUCTIONS

Surgery Date _____ Arrival Time _____ Report Directly to Second Floor

1. The day before your surgery drink plenty of liquids, such as water or juice. Do not drink alcoholic beverages.
 2. Do not eat or drink anything after midnight the night before your surgery. No gum, no mints, no candy, no water, **nothing**.
 3. If you take blood pressure meds, heart meds, seizure meds, stomach meds, or anxiety meds you should take these in the morning with a small sip of water. **DO NOT TAKE DIABETES MEDS, WATER PILLS, OR VITAMINS!** The nurse will be happy to review your medications with you before surgery.
 4. Please take a bath or a shower prior to coming to the Surgery Center. Pay special attention to the surgical site and finger/toe nails.
 5. After bathing do not use any oil, lotion, powder, perfume, after shave, or makeup. You may use deodorant and you may brush your teeth.
 6. Wear clothes that you can get on and off easily. No boots or jeans.
 7. No finger nail polish except clear. No toe nail polish for knee, foot or ankle surgery. Acrylic nails are allowed as long as the polish is clear.
 8. Leave all jewelry at home, including wedding rings. No contact lenses, wigs, hairpieces, or hair clips.
 9. If you have not done so, you will need to bring your drivers license and insurance card. Leave all other valuables at home. No cell phones allowed past the waiting room by patient or family members. No picture taking allowed in any area!
 10. **You must have transportation home from the Surgery Center and someone to stay with you for the first twenty-four (24) hours.** This must be a responsible adult.
 11. Do not bring small children to the Surgery Center. Children under the age of 13 are not allowed in pre-op or recovery room. We **do not** provide babysitting services.
 12. Parent or legal guardian of a minor child having surgery, must remain on the second floor at the Surgery Center at all times.
 13. Our goal is to make your procedure or surgery experience at Outpatient Surgery Center of St. Augustine a safe and pleasant one.
 14. **I have received and reviewed Patient DVT information.**
- If you have any questions or comments please call **904-209-1400**.

Patient _____ Witness _____

OUTPATIENT SURGERY CENTER
 OF ST AUGUSTINE, LLC
 One Orthopaedic Place, Suite 200
 St. Augustine Fl. 32086
 (904)-209-1400

PRE-OP EVALUATION

List allergies	See Medication Reconciliation Form for Medication List Height:_____ Weight:_____ BMI:_____
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Who is your primary care physician? _____ Cardiologist?: _____
 YES NO

Have you or a blood relative ever had a reaction to anesthesia/blood products?
 Nausea/Vomitting Other (specify) _____
 If you are a woman, could you possibly be pregnant? Last menstrual period: _____
 Can you walk a mile without shortness of breath/chest tightness?
 Can you walk up two flights of stairs without shortness of breath/chest tightness?
 Do you get shortness of breath/chest tightness during minimal exertions?
 List any prior surgeries: _____

HEART YES NO If yes, explain at right

High Blood Pressure Treatment? _____
 Chest Pain (Angina) Changed recently? _____
 Heart Attack (MI) When? _____
 Irregular Heart Rythm (dysrhythmia) Specify: _____
 Heart Valve Disease Specify/Symptoms? _____
 Congestive Heart Failure (CHF) Last Symptoms? _____
 Other Heart Problems/VascularDs Medications taken? _____

LUNGS YES NO

COPD (Asthma, Chronic Specify: _____
 Bronchitis, Emphysema) Have you ever required ER visit? ICU? _____
 Sleep Apnea Symptoms?: _____
 TB or other Lung Disorder Specify: _____
 Do you smoke? Specify how long? Packs per day? When quit _____

BRAIN YES NO

Stroke and/or weakness/numbness Specify: _____
 Seizure/Convulsions Last seizure?: _____
 Other brain/nerve/muscle disease Specify: _____

Have you taken intravenous/oral steroids with the last year (ex. Prednisone, Decadron, Hydrocortisone, Medrol)	YES NO	COMMENTS
Do you have diabetes. Thyroid or kidney problems?		_____
Do you have liver disease, hepatitis, jaundice or bleeding disorder		_____
Do you have acid reflux, hiatal hernia or frequent heartburn?		_____
Do you have any other medical problems?		_____

Patient Signature: _____ Date: _____

Fall Prevention Information for Patients and Families

Outpatient surgery Center of St. Augustine's goal is to assist you in achieving your highest level of independence after surgery.

Fall Prevention Program Goals

- To make safety our number one priority.
- To increase your independence while reducing risk of falls.
- To maintain your dignity and respect your rights as a patient.

Patients with the following conditions may be prone to falling:

- History of falls
- Changes in medication
- Vision problems
- Poor balance
- Periods of confusion
- Weakness

Family, caregivers, and staff will be notified of your specific safety needs and are encouraged to work together with the staff to facilitate fall prevention.

Preventing all falls is impossible. However, you will be provided with a safe environment. We will assist you by teaching safe movement, transfer techniques and by alerting you to some common problems you may experience.

Tips for preventing falls while at the Outpatient Surgery Center and at home:

- ❖ **Do not** attempt to get out of bed alone. Please request assistance from the nursing staff while at the surgery center. At home, have a family member with you whenever getting out of bed or ambulating to the restroom.
- ❖ **Nonskid footwear** is a must, do not try to stand or walk in your regular socks.
- ❖ **Inform** your nurse or family member if you feel weak, dizzy or unsteady.

Crutch Use and Gait Instruction:

- ❖ An instruction sheet on proper technique and safety will be provided for you if you will be using crutches after your procedure.

Wheelchair Safety

These basic tips will prevent falls and tipping over in the wheelchair.

- **Position** wheelchair within reach.
- **Lock** both brakes
- **Do not scoot forward in the seat.** If you cannot reach an object, move your wheelchair closer. Position the wheelchair so the object may be reached sideways.

IMPORTANT PATIENT INFORMATION PREVENTING DEEP VEIN THROMBOSIS

Deep vein thrombosis (DVT) is a blood clot that forms in a deep vein, often in the calf or thigh. The clot can partially or completely block blood flow and damage vessels. If a blood clot breaks free, it can travel to the lungs and cause pulmonary embolus (PE), which can be serious.

DVT RISK FACTORS

The risk of developing DVT is greatest during the 10 days following surgery. Other common risk factors include:

- Limited mobility
- Congestive heart failure
- Personal or family history of blood clot
- Smoking
- Overweight
- Respiratory failure
- Medications such as birth control pills or hormones
- Age 40 and older

GENERAL DVT PREVENTION

There are a few things that you can do to prevent DVT. Your doctor and nurse will work with you to determine the DVT prevention methods that are right for you.

- > **Move as soon as possible**-after surgery, get out of bed and move around as soon as your doctor tells you that it is OK to do so. Ask for assistance if you feel unsteady.
- > **Exercises**- Exercising your lower leg muscles is important especially when you sit for long periods of time. It decreases the pooling of blood in your legs. Try to do the DVT prevention exercises below several times a day, while you are recovering from surgery.

DVT EXERCISES

There are a few simple exercises you can do to help prevent DVT, particularly in situations where you are seated for a long time.

Toe lifts- With your heels on the floor, lift the toes and front of foot as high as possible, then put both feet flat on the floor. This keeps your calf muscles working to prevent blood from pooling.

Ankle rotation-Rotate your feet clockwise and counter clockwise for 30 seconds. Sit with your knee bent and circle your foot, first clockwise then counterclockwise. While doing the exercises, be sure you are only moving your foot and ankle. Do both of these exercises several times a day.

Signs that you may have a DVT or PE

In your calf or thigh:

- >Pain
- >Swelling
- >Redness
- >Warm to touch

Or

- >Shortness of breath
- >Palpitations
- >Lightheadedness

If you develop any of the above symptoms in the period after surgery, call your doctor or go to the nearest emergency room.

DVT Prevention when you Travel

The risk of DVT can increase when you take a long car or airplane trip. Tell your doctor if you are planning a trip where you will be in a car or plane for over one hour.

When you are on a long flight or car ride:

- >Use the aisle of the plane or get out of the car to walk every hour.
- >Flex and point your feet at least every 20 minutes
- >Drink a large glass of water every two hours
- >Do not drink beverages containing caffeine or alcohol.

If you have any concerns or questions about DVT or PE please contact your doctor or the nurse.

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