CASCADE SURGICENTER

Patient: _____

DOB: _____

Patient Informed Consent

Procedure(s): _____

_____

☐ Right-side ☐ Left-side ☐ Bilateral ☐ Not applicable

I authorize Practitioner(s): _____ and his/her designated assistants to perform the above procedures.
Additional Information (e.g. risks, benefits, alternatives, anesthesia):_____

_____

1. The procedures, benefits, material risks, and reasonable alternatives were explained to me and all of my questions about the procedures, benefits, material risks, and reasonable alternatives were answered to my satisfaction.
2. I understand that, during the course of the procedures, unforeseen circumstances may necessitate additional or different procedures than those discussed with me. I authorize the practitioners to perform such other procedures as are, in their judgment, necessary and appropriate.
3. I acknowledge that no warranty or guarantee was made to me as to result or cure.
4. I consent to receive blood or blood products as deemed necessary and appropriate by the practitioners if a transfusion is required during or after the procedures.
5. I consent to receive anesthetics, drugs, medicines, and other substances as deemed appropriate by the practitioners. I understand that prior to my procedure, an anesthesiologist from Bend Anesthesiology Group, will discuss my anesthesia plan, alternatives and risks with me or my responsible party, and answer any questions I may have. I realize that impairment of full mental alertness may persist for several hours following the administration of anesthetics and other medications and I will avoid making important decisions or taking part in activities which depend upon full concentration or judgment, and will have a responsible adult drive me home following my procedure.
6. I authorize the use of x-ray and any additional tests deemed necessary by the practitioners for my care.
7. I authorize the disposition of any specimen or tissue taken from my body or to retain the specimen or tissue for purposes deemed appropriate by the practitioners.
8. I consent to the taking and publishing of any photographs in the course of the procedure for the purpose of advancing medical education, provided my identity is protected.
9. I consent to the admittance of qualified observers in the procedure or operating room, such as nursing students, for the purpose of advancing medical education, provided my identity is protected.
10. I consent to the presence of manufactures' representatives during my procedure to provide technical support.
11. I understand that the physicians (e.g. surgeon, anesthesiologist, radiologist, and pathologist) are independent contractors and I will receive a separate bill from them.
12. I understand that Advance Directives and "Do Not Resuscitate" orders will be waived during my surgery and immediate post-operative period at the hospital and for the duration of my admission at the surgery center. I have discussed this with my physician.
13. I consent to serologic testing for Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C in the event following an exposure or direct contact with body fluids with another person's skin or mucous membranes.
14. I realize that following my procedure, admission to a hospital may be advised. I agree to admission at St. Charles Medical Center if, in the opinion of my physician, such admission should be deemed advisable in my best interest.

To receive information by email, please provide your email address: _____.
I would like to receive the following by email: ☐ Financial Information ☐ Patient Satisfaction Survey ☐ Medical Information

I understand by signing this document I consent to the above procedures and I acknowledge receipt of printed information, including but not limited to, Patient Rights and Responsibilities, Advance Directive Notification, Financial Responsibility, and Patient Pre-Procedure Instructions.

_____ _____ _____
(Patient or Authorized Consenter Signature) ☐ Check if Interpreter used (Date) (Time)

_____
(Witness to Signature of Patient or Authorized Consenter) ☐ Check if telephone consent

_____
(Practitioner's Signature)

(Place patient identification label in this box.)

OWNER INFORMATION

Cascade Surgicenter LLC is owned by St. Charles Healthcare System and local surgeons associated with The Orthopedic and Neurosurgical Center of the Cascades, who developed Cascade Surgicenter to facilitate their participation in every aspect of the care provided to their patients. **Your surgeon is likely one of the owners of Cascade Surgicenter and will be glad to answer any of your questions about the center.**

PATIENT RIGHTS

Cascade Surgicenter patients have the right to:

- Receive services without regard to race, color, age, sex, sexual orientation, religion, marital status, handicap, national origin or sponsor.
- Be provided reasonable access.
- Be provided a secure environment for self and property.
- Be treated with respect, consideration, dignity and comfort.
- Expect physicians and staff to respect your privacy and keep all information pertaining to your care confidential.
- Expect that all disclosures and records are treated confidentially, except when required by law, and to be given the right to approve or refuse their release.
- Be given the opportunity to participate in decisions involving your care, except when participation is contraindicated for medical reasons.
- Know by name and position, the persons caring for you. Physicians and staff will introduce themselves and staff will wear identification badges.
- Receive from your physician, information necessary to give informed consent prior to the start of any procedure and/or treatment, except in emergencies.
- Be believed if you say you have pain and to have your pain managed as individually and effectively as possible, a concerned staff member will respond to your reports of pain.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Be free from all forms of abuse or harassment.
- Receive the care necessary to regain or maintain your maximum state of health and if necessary, cope with death.
- Be fully informed of the scope of services available at the facility, provisions for after-hours care and related fees for services rendered.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions including refusal of treatment or not following the instructions of the physician or facility.
- Be informed of any human experimentation or other research/educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Access to and/or copies of his/her medical record.
- Be informed as to the facility's policy regarding advance directives/living wills.
- Be fully informed before any transfer to another facility or organization that has agreed to accept the patient transfer.
- Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.

If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State laws may exercise the patient's rights to the extent allowed by State law.

PATIENT COMPLAINT OR GRIEVANCE

To report a grievance you can contact the facility Administrator by phone at (541) 330-8671 or by mail at:
Cascade Surgicenter ∗ 2200 NE Neff, Suite 100 ∗ Bend OR 97701 ∗ (541) 322-2395

Medicare beneficiaries may receive information regarding their options under Medicare and their rights and protections by visiting the website for the Office of the Medicare Beneficiary Ombudsman at: http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombusdsman.html.

Complaints and grievances may also be filed through:

Oregon Health Division
Health Care Licensing and Certification
800 NE Oregon St., Suite 305
Portland OR 97214-0450
971-673-0540

State of Oregon, CMS Regional Office
DHHS/CMS/DMSO, Mail Stop RX-48
2201 6th Avenue
Seattle, WA 98121
206-615-2710

PATIENT RESPONSIBILITIES

- Be considerate of other patients and personnel and for assisting in the control of noise, eating and other distractions.
- Respect the property of others and the facility.
- Report whether he or she clearly understands the planned course of treatment and what is expected of him or her.
- Keep appointments and, when unable to do so for any reason, notifying the facility and physician.
- Follow the treatment plan prescribed by his or her provider, and participate in his or her care.
- Provide care givers with the most accurate and complete information regarding the present complaints, past illnesses and hospitalizations, medications – including over-the-counter products and dietary supplements, any allergies or sensitivities, unexpected changes in his or her condition, or any other health matters.
- Observe prescribed rules of the facility during his or her stay and treatment, and if instructions are not followed, forfeit care at the facility.
- Promptly fulfill his or her financial obligations to the facility.
- Identify any patient safety concerns.
- Provide a responsible adult to transport him or her home from the facility and remain with him or her for 24 hours, if required by his or her provider.

ADVANCE DIRECTIVE NOTIFICATION

In the State of Oregon, all patients have the right to participate in their own healthcare decisions and to make an advance directive, such as a living will or durable power of attorney for healthcare recognized under State law, authorizing others to make decisions on the patient's behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Cascade Surgicenter respects and upholds those rights. However, unlike in an acute care hospital setting, Cascade Surgicenter does not routinely perform "high risk" procedures. While no procedure is without risk, most procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your procedure.

Therefore, it is our policy, regardless of the contents of any advance directive or instructions from a healthcare surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or healthcare power of attorney. Your agreement with this facility's policy will not revoke or invalidate any current healthcare directive or healthcare power of attorney.

If you wish to complete an advance directive, copies of the official State forms are available at our facility. If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

FINANCIAL RESPONSIBILITY

- As a courtesy, we will bill all insurance plans. If you do not have insurance coverage, please call the Cascade Surgicenter Business Office at 541-322-2395 and ask to speak to a Patient Financial Services Representative.
- Please bring your insurance card and picture identification with you to your procedure. This allows us to verify the correct billing address of your insurance company and verify patient information.
- Cascade Surgicenter is the facility where your procedure will be done. We are considered "in network" with most insurance companies. We strive to stay informed and inform our patients if we are "out of network" with their insurance. You are encouraged to verify Cascade Surgicenter's contract status with your insurance prior to your procedure.
- The facility fee for Cascade Surgicenter does not include the surgeon's and assistant surgeon fees; the anesthesiologist's fees; lab tests done prior to admission or pathology fees (if tissue is removed during surgery); or charges for durable medical equipment (splints, crutches.).
- Your physician's office will notify Cascade Surgicenter of your procedure. Cascade Surgicenter will estimate your patient financial responsibility and a representative from the Business Office will contact you. If a message is left for you, please respond in a timely manner.
- Copays, estimated patient responsibility and deductible (if applicable) are due on or before the day of surgery. Payment arrangements must be made prior to your procedure. Please contact the Cascade Surgicenter Business Office at 541-322-2395 and ask to speak to a Patient Financial Services Representative that will assist you in making arrangements.

CASCADE SURGICENTER

Patient name: _____

Cascade Surgicenter Patient Pre-Procedure Instruction Sheet:

The following instructions are very important for a successful outcome of your procedure. Have it handy when the Pre-admission Nurse calls you, so you can fill in the blanks. Please follow these instructions closely.

General Instructions for All Patients:

- You will be called and given your arrival time one business day prior to your procedure, between 12:00 p.m. and 4:30 p.m. Please call (541) 322-2395 if you have not heard from us by 4:30 p.m.
  My Arrival Time is _____.
- We are located at THE CENTER. Please park in the underground parking lot area (accessed from the west side of the building; go down ramp). Come through doors on underground level and proceed to your left to the Cascade Surgicenter check-in desk.
- **You MUST arrange for an adult to drive you home.**
- Please notify Cascade Surgicenter at 541-322-2395 or call your physician at 541-382-3344 if you develop a sore throat, fever, or illness. This is an elective procedure and may be cancelled if you are ill.
- **Bring driver's license or photo ID, insurance card, and co-payment. Leave all other valuables at home. We cannot be responsible for damaged or lost property.**
- Do not wear perfume, cologne, jewelry or makeup the day of your procedure.

Additional Instructions for Patients Requiring Anesthesia or I.V. Sedation:

- Surgery patients will be contacted by the Preadmission Nurse 2-7 business days prior to surgery date to collect a health history and current medication list, and to make arrangements for additional pre-op testing ordered by your anesthesiologist (i.e. lab work, EKG).
- Do not eat ANYTHING after midnight the night prior to your procedure. Do not chew gum, candy, or use tobacco or tobacco products (chew) on the day of your procedure.
- You may drink clear liquids up to 6 hours before the time you are told to arrive for your procedure. (Includes coffee or tea without milk products, plain Jell-O, soda, Gatorade, clear broth, water, and juice without pulp).
- You may brush your teeth and rinse your mouth any time prior to your procedure (swish and spit out water without swallowing).
- Please shower prior to arrival.
- Wear loose fitting, comfortable clothing, and wear bottom underwear. Females may wear a sports bra without metal or plastic clips (bra with stitching only). Wear comfortable shoes; no high heels.
- If your surgery requires crutches or walker after your procedure, please bring them with you and leave them in your car. Bring them inside if you are scheduled to have pre-op crutch training (a nurse will arrange crutch training during the pre-op call).
- Bring the following items related to your surgery: _____.
- OK to take the following medications with a sip of water on the day of surgery: _____.
- Do not take the following medications on the day of surgery: _____.
- Please bring the following items if needed: Insulin; snack if you have a gluten allergy; asthma inhaler; pacemaker or cardio defibrillator manufacturer information; C-PAP machine.
- Bring hearing aid(s), glasses or contact lenses and supplies/cases.
- Leave a pillow and blanket in your car for your ride home.
- Please limit family members or friends: 1 for adults and 2 for children.
- **You MUST arrange for an adult to drive you home and to stay with you through the entire night (preferably for 24 hours), or your procedure may be cancelled.**
- Call the pre-op nurse at (541) 322-2397 if you have any questions.
- While you are in surgery, your family member, friend, or significant other will be asked to wait in the front lobby waiting area. Your surgeon will speak with him/her immediately following your surgery. If he/she is not present when the surgeon attempts to speak with him/her, he/she may need to wait to speak with your surgeon at your next office appointment.