Surgical Center
AT CEDAR KNOLLS

ADULT – Patient Medical History Questionnaire

NAME	AGE	HEIGHT	WEIGHT	SURGEON	DATE of SURGERY

List All Allergies

Present Medications

Past Operations You Have Had and Their Dates

Past Hospitalizations and Diagnosis

☐ YES ☐ NO Have you or anyone in your family ever had a serious problem with Anesthesia?
If YES, Please Describe

☐ YES ☐ NO Recent Cold or Flu?

☐ YES ☐ NO Do You Smoke? How Long? How Many Packs a Day?

☐ YES ☐ NO Do You Take Recreational Drugs? e.g. Cocaine, Marijuana. Please list.

☐ YES ☐ NO Do You Drink Alcohol? How Often? How Much?

☐ YES ☐ NO Loose Teeth, Caps, Partial Bridge?

☐ YES ☐ NO Lung Disease, Asthma, Bronchitis, Emphysema, Sleep Apnea

Last Time You Were Wheezing?

☐ YES ☐ NO Shortness of Breath Upon Climbing Up A Flight Of Stairs or Less?

☐ YES ☐ NO Heart Attack?

☐ YES ☐ NO Congestive Heart Failure?

☐ YES ☐ NO Angina or Pain in the Chest and How Often?

☐ YES ☐ NO Past stress Test or Cardiac Catheterization and Results, Date ______

☐ YES ☐ NO Irregular Heart Beats? ______

☐ YES ☐ NO High Blood Pressure? ______

☐ YES ☐ NO Stroke? ______

☐ YES ☐ NO Anemia, Sickle Cells or Other Blood Diseases? ______

☐ YES ☐ NO Diabetes? ______

☐ YES ☐ NO Thyroid Problems? ______

☐ YES ☐ NO Kidney Problems? ______

☐ YES ☐ NO Liver Problems? ______

☐ YES ☐ NO Epilepsy or Seizures? ______

☐ YES ☐ NO Headaches, Back or Neck Pain? ______

☐ YES ☐ NO Weakness or Numbness in a Limb? ______

☐ YES ☐ NO Excessive Bleeding or Bruising? E.G. Nosebleed ______

☐ YES ☐ NO Hiatal Hernia? ______

☐ YES ☐ NO Arthritis or Rheumatological Disease? ______

☐ YES ☐ NO Other Significant Illnesses? ______

☐ YES ☐ NO FEMALE PATIENTS: Could You Be Pregnant? ______

Who is your Medical Doctor (Not Surgeon) ______

Has your Medical Doctor Cleared you for Surgery? YES ☐ NO ☐

I understand that I am not to eat or drink as instructed prior to the day of Surgery unless instructed otherwise by The Surgical Center at Cedar Knolls Staff. I also understand that I must have a responsible adult accompany me home after discharge from The Surgical Center at Cedar Knolls.

______
Signature of Patient or Legal Guardian

PT ID

OUR CONCERN FOR YOUR SAFETY

The Surgical Center at Cedar Knolls, LLC continue to strive to make health care safety a priority. You, as the patient, can also play a role in making your care safe by becoming an active, involved and informed member of your health care team.

While you are a patient at our facility, we want you to feel comfortable to do the following:

- Expect our nursing staff to introduce themselves when they enter your room, and look for their nametags.
- Ask about the purpose of medications you are given, including possible side effects. Make sure you can read the handwriting on any prescriptions written by your doctor. Don't be afraid to tell the nurse or doctor if you think you are about to receive the wrong medication.
- Don't hesitate to tell a member of our staff if you think he or she has confused you with another patient.
- Expect our clinical staff to have washed their hands.
- Make sure your nurse or doctor confirms your identity, that is, checks your wristband and asks your name and birth date, before he or she administers any medication or treatment.
- Educate yourself about your diagnosis and planned surgical procedure.
- Thoroughly read all forms and the consent for surgery and make sure you understand them before signing. If you don't understand, ask our staff or your doctor to explain them.
- Expect your doctor, with your participation, to mark the area that is to be operated upon.
- Prior to leaving our facility, be sure that you understand all of the post-operative instructions.
- Consider asking your companion to ask questions that you may not think of, to help remember answers to questions you have asked, and to speak up for you if you cannot.
- Make sure your companion understands the type of care you will need when you get home. Your companion should know what to look for if your condition gets worse and whom to call if help is needed.
- Please speak up if you have questions or concerns, and if it is still unclear, ask again. Don't hesitate to ask about your safety. Tell your nurse or doctor if something doesn't seem quite right.
- Participate in all decisions about your treatment.

PLEASE ASK TO SPEAK TO A MANAGER IF YOU HAVE ANY CONCERNS ABOUT YOUR SAFETY

Patient Signature: ______________________

SURGICAL CENTER AT CEDAR KNOLLS
STATEMENT OF PATIENT'S RIGHTS

As a patient at the Surgical Center at Cedar Knolls you have the right, consistent with the law, to:

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
2. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;
4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option on no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;
6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal; If you are not satisfied with the Center's response you can direct your complaint to the New Jersey State Department of Health at (800) 792-9770 or in writing to the Director of Licensing Certification and Standards.
8. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;
9. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
10. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;
11. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;
12. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient;
13. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility;
14. To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care in accordance with N.J.A.C. 8:43E-6.
15. I have received information from my doctor's office on: 1) Advance Directives and 2) that he/she have a financial interest in the Center. For more information on Advance Directives please visit: http://www.nj.gov/health/

As a patient you are responsible for:

The *Surgical Center at Cedar Knolls* needs the cooperation of its patients to ensure that efficient, safe and considerate care is available to all, and requests patients to:

1. Provide physicians and Center personnel with accurate information related to their condition and care;
2. Follow their treatment plans. Patients are responsible for medical consequences that result from refusing treatment or not following instructions of physicians and hospital personnel;
3. Be considerate of the Center's staff that is committed to excellence in patient care;
4. Supply insurance information and pay bills promptly so that the *Surgical Center at Cedar Knolls* can continue to serve you effectively.

Patient Signature ______________________ Date ______________________

Witness ______________________ Date ______________________

Surgical Center
AT CEDAR KNOLLS

197 Ridgedale Avenue, Cedar Knolls, NJ 07927

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the **Notice of Privacy Policies** for the groups listed above, detailing how my Protected Health Information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

____

____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:__________________________ **Date:**________________________

If not signed by patient, please indicate relationship to patient (e.g., spouse, guardian)

Relationship: ________________ **Witnesses by:**______________________

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):________________________________

By: (name and title): ____________________________________

Stated reason for refusal to sign: ____________________________________

____

Surgical Center

AT CEDAR KNOLLS

197 Ridgedale Ave, Cedar Knolls, NJ 07927

ADVANCED DIRECTIVE-LIVING WILL

On January 11, 1992, a New Jersey law took effect which mandates that all health insurance facilities ask patients whether they have an advance directive or living will. At the *Surgical Center at Cedar Knolls* we will suspend this part of the process.

If you have an advance directive or living will, please bring a copy of it to the *Surgical Center at Cedar Knolls* the day of your procedure.

An advance directive or living will is used by an individual to indicate their voluntary, informed choice of accepting, rejecting, or choosing among alternative courses of medical treatment.

An advanced directive or living will is a document which allows you to give written instructions to those caring for you, indicating the type of health care you would wish to receive or reject in the event you become unable to express the decisions yourself.

There are three different types of advanced directives:

1. A Proxy Directive: This is a document in which a competent adult names a trusted relative or friend to make health care decisions on their behalf when they are unable to make these decisions.
2. An Instruction Directive: In this document, the person writing it provides written instructions concerning the type of medical treatment they want or do not want performed for them and under what circumstances.
3. A Combined Directive: In this document, a competent adult states their general wishes regarding the kind of health care they wish to receive, but appoint a trusted relative or friend to carry them out.

A brochure containing living will information is available from the Division of Aging, if you wish to receive the brochure, please make your request to:

The Division of Aging
101 South Broad Street
CN 807
Trenton, NJ 08625

Do you have an Advanced Directive or Living Will? __________ YES ___________ NO

If YES, see Waiver of Advance Health Care Directive.

Patient's signature indicating awareness of the above: __________________ ***Date*** ________

Time ________________________ ***Witness*** ____________________________

Surgical Center
AT CEDAR KNOLLS

ASSIGNMENT OF BENEFITS

RE: ______________________________
PATIENT'S NAME

If NF or WC, DATE OF ACCIDENT: ___________________

I hereby assign all my benefits and rights from insurance company __________________ to the medical provider designated below. I assign all rights to pursue payment for services rendered to me by this medical provider and the medical provider may proceed against said insurance company obligated to make payment to me or to this medical provider for services rendered to me. In the event that the insurance company refuses to make such payment upon demand, I expressly give permission for a cause of action to be brought in my name as assignee.

A photocopy of this assignment may be valid as if it was an original.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that if another attorney is substituted in this matter, the new attorney honor the within assignment.

DATED:___________________

____
PATIENT'S SIGNATURE

Surgical Center at Cedar Knolls, LLC
197 Ridgedale Ave
Cedar Knolls, NJ 07927

____
MEDICAL PROVIDER

Surgical Center
AT CEDAR KNOLLS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(Complete in Full)

____
Name of Patient

____
Street Address

____
City, State, Zip code

____
Date of Birth

____
Phone

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to the Surgical Center at Cedar Knolls, LLC. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. AUTHORIZE:

Surgical Center at Cedar Knolls, LLC
197 Ridgedale Avenue
Cedar Knolls, NJ 07927

3. TO RELEASE PROTECTED HEALTH NFORMATION TO:

____
(Name of Person/Physician/Health Care Facility/Other)

____
(Street Address)

____
(City, State, Zip Code)

4. HEALTH INFORMATION TO BE RELEASED:

☐ Complete Medical Record ☐ Xray ☐ Abstract of Medical Record ☐ Pathology Reports
☐ Demographic/Visit History ☐ Lab ☐ History & Physical Exam ☐ Operative Reports
☐ Discharge/Transfer Summary ☐ EKG ☐ Consultation Reports ☐ Other: ____________

5. PURPOSE OR NEED FOR DISCLOSURE:

____

6. DELIVERY MODE:

☐ Patient/Designee to Hand-Carry. ☐ Mail photocopies to the address in 3. ☐ Fax to Person/Facility in 3.

7. EXPIRATION:

This authorization will expire on ______/______/______(MM/DD/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below. A photocopy of this authorization is as valid as the original.

8. SIGNATURE:

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will automatically expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at (973) 292-0700.

______________________________ ______________________________
Patient / Legal Representative Signature Date

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.