Innovative Procedural and Surgical Center

9920 West Cheyenne Ave., Ste. 120, Las Vegas, NV 89129
(Next to the Las Vegas Metropolitan Police Academy)

P: (702) 998-7179
F: (702) 405-7676
PainFreeNevada.com

To Our Valued Patient,

Thank you for choosing Innovative Procedural and Surgical Center for your healthcare needs. We are a multi-specialty outpatient Ambulatory Surgery Center with a focus in interventional pain management. Your procedure or surgery will be performed in a full-service operating room with specialized staff. We are dedicated to providing you quality care in a safe and clean environment; with a team of highly competent and caring staff.

Our Goals Are:

- To be a center of excellence in providing surgical services and related patient care.
- To streamline delivery of medical care to the surgical outpatient and provide the utmost quality services using current methods and techniques, evidence-based practice, and new and up-to-date technology and equipment.
- To create an outpatient surgical experience in a less stressful environment.
- To provide an environment aesthetically pleasing for the patient, physician, and employee with emphasis on customer service.
- To reduce or eliminate the risk of infection for the surgical patient during the perioperative process.

Who We Are and What We Do

As our name implies, we are an ambulatory surgical center or ASC. An ASC is a type of outpatient health care facility focused on providing same-day surgical care, including diagnostic and preventive procedures[1]. Our expectations are that patients recover and go home the same day. The types of surgeries performed at an ASC differ from center to center. Some are single specialty while others provide multi-specialty coverage. We are focused in pain management and are equipped to provide services in spine, orthopedic, general, and plastic surgery. In comparison to a hospital, not all resources are available to ASCs. This means certain surgical services, care for overnight stays, and emergency department services are not available on sight. If you have any questions about services or operating standards at Innovative Procedural and Surgical Center please ask a staff member for more information.

Accreditation

Innovative Procedural and Surgical Center is federally certified by the Centers of Medicare & Medicaid Services (CMS), through its Medicare Program. We are accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Accreditation status through AAAHC means that our organization meets or exceeds nationally-recognized standards for quality care and patient safety.

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INFORMATION SHEET

FOR PATIENTS UNDERGOING PAIN MANAGEMENT INJECTIONS OR PROCEDURES

By now you have discussed your procedure with your surgeon. Please communicate with your doctor and ensure that all your questions and concerns have been answered to your satisfaction. Please notify your doctor prior to your procedure for any changes in your physical condition such as a fever or cold.

To Ensure A Complete and Timely Admission Process:

- Complete the attached patient packet and bring it with you on the day of your procedure. This paperwork is completely separate and different from Innovative Pain Care Center or your surgeon's office. This paperwork must be completed prior to the start of your procedure.
- If you have not received or are missing parts of the patient packet please contact the front desk at (702) 998-7179 and request a packet. Patient packets are available for pick-up at the front desk or can be mailed, faxed, or emailed.

Prior to Surgery:

- If you are planning to receive anesthesia or sedation for your procedure please do not eat or drink anything 6 hours prior to your procedure. This is very important for your safety.
- If you are taking medications that can thin your blood (anticoagulants and certain anti-inflammatory medications), your doctor will want you to stop taking them for a specific period of time prior to your procedure. Please contact your doctor or a preoperative nurse at the center if you have not received instructions about your blood thinners.

The Morning of Your Procedure:

- Dress comfortably in clothing that can be easily removed and fits loosely, so not to bind your procedure site. We recommend pants or shorts with an elastic waistband such as sweatpants or athletic shorts.
- Leave all jewelry and valuables at home.
- Please arrive at the center at your instructed time. It is important to be prompt for your appointment to avoid cancellations.
- Please bring a responsible adult who will transport you home after your procedure. You are required to have a responsible adult driver to take you home. No Uber or public transportation unless accompanied by a responsible adult.
- Please bring your health insurance card, photo ID, and list of current medications.
- Please bring a credit card for payment of deductibles and/or co-payments.

What to Expect After Your Procedure:

- Your surgeon and the nursing staff will provide you with written instructions for your post-operative care. Please follow these instructions carefully.
- Your doctor may have you document and monitor your pain status after your procedure. If you are given a form please complete and submit it to your doctor at your next follow-up appointment.
- Your doctor and nursing staff will assess the after-effects of your procedure to monitor the progress of your recovery.

Your time is important to us. We understand waiting to undergo a procedure can create anxiety and increase stress levels. To help us ensure a safe and timely surgery process, please follow the directions listed on this form and complete this paperwork in its entirety. Please arrive to your appointment during the designated check-in times. Arriving earlier than your instructed check-in time will not guarantee an earlier start and can lead to you waiting longer than expected. We value your time and are dedicated in providing you a safe surgical experience.

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INFORMATION SHEET

FOR PATIENTS UNDERGOING GENERAL SURGERY

By now you have discussed your procedure with your surgeon. Please communicate with your doctor and ensure that all your questions and concerns have been answered to your satisfaction. Please notify your doctor prior to your procedure for any changes in your physical condition such as a fever or cold.

To Ensure A Complete and Timely Admission Process:

- Complete the attached patient packet and bring it with you on the day of your procedure. This paperwork is separate and different from Innovative Pain Care Center or your surgeon's office. This paperwork must be completely completed prior to the start of your procedure.
- If you have not received or are missing parts of the patient packet please contact the front desk at 702-998-7179 and request a packet. Patient packets are available for pick-up at the front desk or can be mailed, faxed, or emailed.

Prior to Surgery:

- Do not eat or drink anything after midnight. This is very important for your safety.
- If you are taking medications that can thin your blood (anticoagulants and certain anti-inflammatory medications), your doctor will want you to stop taking them for a specific period of time prior to your procedure. Please contact your doctor or a preoperative nurse at the center if you have not received instructions about your blood thinners.
- Your surgeon or anesthesiologist may order laboratory work prior to your surgery. Please confirm this with your doctor prior to your scheduled surgery date.

The Morning of Your Procedure:

- Dress comfortably in clothing that can be easily removed and fits loosely, so not to bind your procedure site. We recommend pants or shorts with an elastic waistband such as sweatpants or athletic shorts. Leave all jewelry and valuables at home.
- Please arrive at the center at the instructed time (usually one hour prior to your schedule). Unless instructed, do not arrive earlier than this time as it may potentially increase your wait time.
- Please bring a responsible adult who will transport you home after your procedure. You are required to have a responsible adult driver to take you home. No Uber or public transportation unless accompanied by a responsible adult.
- Please bring your health insurance card, photo ID, and list of current medications.
- Please bring a credit card for payment of deductibles and/or co-payments.

What to Expect After Your Procedure:

- Your surgeon and the nursing staff will provide you with written instructions for your post-operative care. Please follow these instructions carefully.
- Your doctor and nursing staff will assess the after-effects of your procedure to monitor the progress of your recovery.
- A surgical dressing will be present at your surgery site. Specific instructions will be given to you regarding care of your surgical site. Please follow these instructions carefully.

IMPORTANT – PLEASE READ

If you have not received information from Innovative Procedural and Surgical Center on Patient Rights, Advance Directives, or physician ownership interests, please call the appropriate number below before the day of your procedure.
IPSC: (702) 998-7179

Innovative Procedural and Surgical Center (IPSC) is a separate and distinct facility from Innovative Pain Care Center (IPCC).
Charges reflect only procedures performed at IPSC.
Any money paid to your physician's office has no relation to money you may owe at Innovative Procedural and Surgical Center.

PLEASE NOTE

MEDICATIONS MUST BE WRITTEN ON THE MEDICATION LIST FORM WITH THE DATE AND TIME MEDICATIONS WERE LAST TAKEN. BRING A LIST OF ALL MEDICATIONS AND SURGERIES TO EVERY APPOINTMENT YOU ARE REQUIRED TO UPDATE THIS INFORMATION AT EVERY APPOINTMENT.

Thank You
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Innovative Procedural and Surgical Center is committed to providing the highest level of patient care. To achieve this objective, we ask our patients or their caretaker to complete a brief patient satisfaction survey after their visit.

To better serve you we have automated this process. Within 72 hours, you will receive an email providing you with a link to complete our survey. The survey is performed online via a secure internet connection to the independent company we have hired to gather survey results. Simply follow the instructions and give us your feedback.

Please write legibly and provide the email address to forward the survey to in the boxes below:

Please check here ☐ If you do not have email, please let us know and we will provide you with a paper version of the survey to complete and return to us.

Privacy Statement: We are committed to protecting the confidentiality of our patient's information and identities and under no circumstances will your information be disclosed or used for marketing purposes.

You will need a driver after your procedure to drive you home.
Please provide the information below, even if your driver plans on staying in the waiting area.

Driver's Name _____

Relationship to Patient _____

Telephone Number for Driver _____

Secondary Number _____

☐ My driver will stay in waiting area during my procedure.

☐ Please call my driver when I am about ready to be picked up.

☐ My driver may leave the facility, please call them if they are not in waiting area.

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REGISTRATION FORM

Referring Physician _____

Last Name _____ First name _____ Middle Initial _____

Street Address _____ City _____ State _____ Zip _____

DOB _____ Age _____ SSN _____ Primary Care Physician _____

Home Phone _____ Cell Phone _____ Email _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYMENT INFORMATION

Employer _____ Address _____

City _____ State _____ Zip _____ Phone # _____

Occupation _____ Other: ☐ Not employed ☐ Retired ☐ Disabled ☐ Student

INSURANCE INFORMATION

Primary Insurance _____ Start Date _____

Member / Policy # _____ Group Name / Number _____

Policyholder's Name _____ SSN _____ DOB _____

Policyholder's Employer _____ Relation to patient: ☐ Self ☐ Spouse ☐ _____

Secondary Insurance _____ Start Date _____

Member / Policy # _____ Group Name / Number _____

Policyholder's Name _____ SSN _____ DOB _____

Policyholder's Employer _____ Relation to patient: ☐ Self ☐ Spouse ☐ _____

ATTORNEY INFORMATION

Law Firm _____ Attorney _____

Address _____

Phone Number _____ Fax _____ Email _____

Start Date _____ Date of Injury (DOI) _____

EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Phone _____

Relation to Patient: ☐ Spouse ☐ Parent ☐ Caregiver ☐ Sibling ☐ Child ☐ _____

WE HAVE VISUAL, AUDITORY, INTERPRETIVE (LANGUAGE AND AMERICAN SIGN LANGUAGE) SERVICES AVAILABLE TO YOU FREE OF CHARGE

****DO YOU REQUIRE ANY SPECIAL ASSISTANCE?** ☐ **YES** _____ ☐ **NO**

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Innovative Procedural & Surgical Center medical benefits, if any, from my insurance carrier that would otherwise be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the surgery center to release all information necessary to secure the payment of benefits and/or further medical treatments. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient or Responsible Party Signature _____ **Date** _____

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PRE-ANESTHESIA RECORD **ALLERGIES:** _____ **HEIGHT:** _____ **WEIGHT:** _____ **LBS**

	Y	N		Y	N
1. Have you or your family member had a high fever or unexplained fever during / after surgery? Explain:_____	☐	☐	**Do you have or have you had: If " yes " please describe.**		
2. Have you or your family ever had a complication from anesthesia? Explain: _____	☐	☐	26. Diabetes: ☐ Insulin ☐ Oral meds ☐ Diet	☐	☐
3. Do you have a rubber or latex allergy or sensitivity?	☐	☐	27. Heart Disease: (Mitral Valve Prolapse, Heart Attack, Angina, Palpitations)	☐	☐
4. Do you have sleep apnea? If yes, do you use c-pap or bi-pap? _____	☐	☐	28. Hepatitis: If yes, Type ☐ A ☐ B ☐ C	☐	☐
5. Do you snore?	☐	☐	29. Hypertension (High Blood Pressure)	☐	☐
6. Has anyone said you stop breathing for periods while you sleep?	☐	☐	30. Pacemaker / Defibrillator	☐	☐
7. Do you drink alcohol ? How often _____ Last Drink _____	☐	☐	31. Asthma ? Last Attack _____	☐	☐
8. Do you smoke? How many cigarettes a day _____	☐	☐	32. Lung Disease	☐	☐
9. Are you pregnant or could you be ?	☐	☐	33. Cancer, What type _____	☐	☐
10. Date of last menstrual period _____	☐	☐	34. Kidney Disease, On dialysis ?	☐	☐
11. Taking any blood thinners ? (Aspirin, Plavix, Coumadin) If yes, last taken when _____	☐	☐	35. Bleeding / clotting problems ? Blood transfusion?	☐	☐
12. Taking any anti-inflammatories ? (Ibuprofen, Celebrex) If yes, last taken when _____	☐	☐	36. Thyroid Disease	☐	☐
13. Have you had an abnormal EKG?	☐	☐	37. Seizures or epilepsy	☐	☐
14. Have you had an abnormal Chest x-ray?	☐	☐	38. Stroke	☐	☐
15. Any recent weight change? (significant amount)	☐	☐	39. Back or neck problems	☐	☐
16. Do you have or wear: (Please Check) ☐ Dentures ☐ Partials ☐ Caps ☐ Contact Lenses	☐	☐	40. Severe Headaches	☐	☐
17. Do you have any body piercing ?	☐	☐	41. Frequent Heartburn	☐	☐
18. On oxygen at home ? How many liters _____	☐	☐	42. Broken facial bones	☐	☐
19. Any shortness of breath ?	☐	☐	43. Glaucoma	☐	☐
20. Do you have any metal implants ?	☐	☐	44. AIDS or HIV Positive	☐	☐
21. Do you have arthritis ?	☐	☐	45. Staph Infection (MRSA)	☐	☐
INITIAL VISIT			46. Vancomycin Resistant Enterococcus (VRE)	☐	☐
PATIENT SIGNATURE:			47. Tuberculosis or any of these symptoms: ☐ Night Sweats ☐ Coughing up blood ☐ Cough ☐ Unexplained weight loss	☐	☐
DATE/TIME:					
REVIEWED BY PRE - OP RN SIGNATURE:			**Please list your previous surgeries and dates**		
SECOND VISIT: Return within 30 days. No changes.					
Verified By: ☐ **Patient** ☐ **Pre-op Nurse**					
THIRD VISIT: Return within 30 days. No changes.					
Verified By: ☐ **Patient** ☐ **Pre-op Nurse**					

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MEDICATIONS MUST BE WRITTEN DOWN ON THE

MEDICATION LIST FORM ALONG WITH THE

DATE AND TIME MEDICATIONS WERE LAST TAKEN.

THANK YOU

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PATIENT HOME MEDICATION LIST*

*Home medication list as provided by the patient

Include all medications you have been on in the last 90 days: prescriptions, over the counter, herbals, vitamins, birth control, and/or patches

ALLERGIES:

You may resume taking all medications as prescribed, except for blood thinning medications/ anticoagulants (Aspirin, Plavix, Coumadin etc.) which you can begin taking again the day after your procedure or as instructed by your doctor.

Name of Medication	Dosage	Frequency	Reason	Last Taken (Date & Time)	Last Taken (Date & Time)	Last Taken (Date & Time)

****** Please contact your prescribing physician for any questions regarding your medications ******

Reviewing Pre-Op RN Signature	**Copy Given to Patient Reviewed with PACU RN**	**Date**
Reviewing Pre-Op RN Signature	**Copy Given to Patient Reviewed with PACU RN**	**Date**
Reviewing Pre-Op RN Signature	**Copy Given to Patient Reviewed with PACU RN**	**Date**

Patient Label

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IMPORTANT – PLEASE READ

Ownership Information:

Your physician may or may not be an owner in the surgery center.
The owners of Innovative Procedural and Surgical Center are:
Dr. Daniel Burkhead, Dr. Ho Viet Dzung, Dr. James Forage, Dr. Willis Wu and Dr. Ryan West.

The Credentials of Your Healthcare Provider:

All physician members at Innovative Procedural and Surgical Center hold an active state license and national board certification in their respective specialty. For information regarding your healthcare providers credentials please visit the following websites for more information.

Board of Medical Examiners:
http://medboard.nv.gov/

Nevada State Board of Osteopathic Medicine:
https://license.k3systems.com/LicensingPublic/

Malpractice Coverage:
All physician members maintain malpractice coverage in compliance with facility membership requirements, federal regulations, and state regulations.

Patient Acknowledgement _____ **Date** _____

Witness Signature (IPSC STAFF) _____

Patient Label

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PATIENT FINANCIAL ACKNOWLEDGEMENT

We want to thank you for choosing Innovative Procedural and Surgical Center for your healthcare procedures. We look forward to providing you with excellent care and service.

Innovative Procedural and Surgical Center is not contracted with all health insurers and payors. In many instances we will be considered an “out-of-network provider”. Please be assured we do not intend to cause you, our patient, any financial hardship for choosing our center.

Our staff will contact your insurance company to verify that your benefits are current and the procedure you are having is an approved procedure. We will also obtain information regarding your responsibilities as a patient for an ambulatory surgical procedure. This specific information relates to your responsibility for co-payment and deductible. Again, we will be finding out information for both in-network and out-of-network benefits.

Your in-network co-payment and deductible responsibility will be collected at the time of your surgery.

After your surgery, the Center will submit a bill to your insurance company. The Center will receive payment from the insurance company and you will receive an explanation of benefits (EOB) from the insurance company. **This is not a bill.**

The Surgery Center will credit your account with the insurance payment and any adjustments you are eligible for through your in-network benefits. A final statement will be sent to you showing this credit to your account and any balance you may be responsible for. We ask you to call to discuss this balance if you have questions at any time.

There are insurance companies that may send a check directly to you. That check is payment owed to the facility for your procedure. You are legally responsible for turning that payment over to the Surgical Center upon receipt.

Again, it is not the intention of Innovative Procedural and Surgical Center to cause you any financial hardship. We look forward to meeting you and providing care in a pleasant, state of the art environment.

Administration of Innovative Procedural and Surgical Center,

Patient Acknowledgement _____ **Date** _____

Witness Signature (IPSC STAFF) _____

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FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

To provide timely and accurate payment to Innovative Procedural and Surgical Center ("IPSC") for any services furnished the patient listed above by IPSC physicians and health care providers (hereinafter, "Services"):

- I certify that the health insurance plan and/or government funded healthcare program information that I have provided is accurate, complete, and current, and that no other coverage or insurance exists (each a "Health Insurance Plan").
- I request that payment of authorized benefits under my Health Insurance Plan(s), if any, be made on my behalf directly to IPSC for the Services.
- I hereby assign to IPSC my right to receive payment of authorized benefits under my Health Insurance Plan(s), if any, regardless of IPSC's network participation status with my Health Insurance Plan(s), and I authorize IPSC to receive such payment.
- I authorize IPSC to take all necessary steps to pursue payment for the Services from my Health Insurance Plan(s), including but not limited to the right to pursue all administrative appeals, the right to file suit, and the right to pursue litigation on my behalf for any denial of payment and/or adverse benefit determination related to or deriving from the Services.
- I hereby assign to IPSC my right to pursue all causes of action against my Health Insurance Plan(s) related to or deriving from the Services, including but not limited to the right to pursue claims under the Employee Retirement Income Security Act (ERISA) and/or the Patient Protection and Affordable Care Act ("ACA"). IPSC may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at no additional expense to me.
- I hereby designate IPSC as my authorized representative in pursuing payment for the Services from my Health Insurance Plan(s), and in pursuing other causes of action related to or deriving from the Services, including but not limited to any and all administrative appeals, litigation, ERISA claims, and/or ACA claims. As my designated representative, IPSC is given the right by me, without limitation, to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any appeal phone conferences, meetings or hearings; (6) participate in any administrative and judicial actions and pursue claims or choose an action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.
- If my Health Insurance Plan(s) will not or does not direct payment to IPSC, I agree to promptly forward to IPSC all health insurance payments which I receive for the Services.
- I authorize IPSC or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan(s) such information needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:

- That **IPSC is not a participating or "in-network" provider with _____ [insert name of insurer]** and that all Services will be billed on an "out-of-network" basis.
- That I am responsible for all charges for Services provided to the patient listed above which are not covered by my Health Insurance Plan(s) or for which I am responsible for payment under my Health Insurance Plan(s).
- That I agree to pay all charges which are not covered by my Health Insurance Plan(s) or for which I am responsible for payment under my Health Insurance Plan(s).
- That, unless earlier revoked, this Financial Responsibility, Assignment of Benefits, and Designation of Authorized Representative form applies and extends to subsequent visits and services at IPSC for the patient listed above.
- **If I receive payment from my Health Insurer directly, I will immediately sign it over to IPSC and that if I fail to pay such payment to IPSC, they may pursue an action against me;**
- **and I further agree that, to the extent permitted by law, I will reimburse IPSC for all costs, expenses and attorney's fees that maybe incurred by IPSC to collect those charges from me.**
- I certify that I have read the above statements, that all my questions have been answered to my satisfaction, and that I agree with each statement above. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Patient/Person Legally Responsible _____ **Relationship to Patient** _____

Witness Signature (IPSC STAFF) _____ **Date** _____

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PATIENT RIGHTS

THE PATIENT HAS THE RIGHT TO:

1. Receive the care necessary to help regain or maintain his or her maximum state of health in a safe setting.

2. Expect personnel who care for the patient to be friendly, considerate, respectful, and qualified through education and experience and perform the services for which they are responsible with the highest quality of service.

3. If a patient is adjudged incompetent under applicable state laws by a court of proper jurisdiction, the rights of the patient can be exercised by the person appointed under state law to act on the patient's behalf.

4. If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.

5. Be free from all forms of abuse or harassment, and to exercise his or her rights without being subjected to discrimination or reprisal.

6. Expect full recognition of individuality, including privacy in treatment and care. In addition, all communications and records will be kept confidential.

7. Complete information in layman's terms, to the extent known by the physician, regarding diagnosis, treatment, and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment.

8. Receive an informed consent to the physician prior to the start of a procedure.

9. Be fully informed of the scope of the services available at the facility including but not limited to; provisions for after-hours and emergency care, payment policies, fees for services rendered, the credentials of health care professionals, information regarding the absence of malpractice insurance coverage, or their right to change their provider if other providers are available.

10. Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.

11. Receive a second opinion concerning the proposed surgical procedure, if requested.

12. Refuse treatment to the extent permitted by law and be informed of the medical consequences of such a refusal. The patient accepts responsibility for his or her actions should he /she refuse treatment or not follows the instructions of the physician or facility.

13. Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third-party payment contract. Personal records are accessible.

14. Be informed of human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.

15. Express grievances/complaints and suggestions at any time. To file a complaint or grievance at any time please notify:

Innovative Procedural and Surgical Center 9920 W. Cheyenne Ave. STE. 120 Las Vegas, Nevada 89129 Phone: (702) 998-7179 Fax: (702) 405-7676 ATTN: Administrator	State of Nevada Bureau of Health Care Quality and Compliance 4220 S. Maryland Pkwy. STE. 180 BLDG. D Las Vegas, Nevada 89119 Phone: (702) 486-6515 Fax: (702) 486-6520 Email: BLCweb@health.nv.gov
Consumer Health Assistance Bureau 555 E. Washington Ave. STE. 4800 Las Vegas, Nevada 89101 Phone: (888) 333-1597	Accreditation Association for Ambulatory Health Care, INC. 5250 Old Orchard Rd. STE. 250 Skokie, Illinois 60077 Phone: (847) 853-6060 Fax: (847) 853-6118 www.aaahc.org/institute
For Medicare Beneficiaries-Medicare Ombudsman http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html	

16. Change primary or specialty physicians or dentists if other qualified physicians or dentists are available and to be informed if a physician does not have malpractice coverage. The Innovative Procedural and Surgical Center requires that all physicians possess malpractice coverage. The patient has a right to request his/her surgeon's credentials.
17. Have an advance directive, such as a living will or healthcare proxy. A patient who has an advance directive must provide a copy to the facility and his or her physician so that his or her wishes may be known and honored, upon transfer to a higher level of care from IPSC.

    The Innovative Procedural and Surgical Center does not honor advance directives pertaining to the termination of life support functions.
18. Expect emergency procedures to be implemented without necessary delay. The expedient and professional transfer to another facility when medically necessary and to have the responsible person and the facility that the patient is transferred to notified prior to transfer.
19. Be fully informed before any transfer to another facility or organization.
20. Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.
21. Not to be subjected to misleading marketing or advertising regarding the competence and capabilities of the center.
22. Have access to an interpreter whenever possible.
23. Know what surgery center rules and regulations apply to my conduct as a patient.

I HAVE READ AND FULLY UNDERSTAND MY RESPONSIBILITIES AS A PATIENT

Patient/ Parent Signature _____ **Date** _____ **Time** _____

Witness Signature (IPSC STAFF) _____

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PATIENT RESPONSIBILITIES

THE PATIENT IS RESPONSIBLE FOR:

1. Be respectful of physicians, staff members, and other patients. Assist in the control of noise, smoking, and other distractions. Respecting the property of others and the facility.

2. Informing the Innovative Procedural and Surgical Center about any living will, medical power of attorney, or advance directive that could affect his/her care. Innovative Procedural and Surgical Center does not honor living wills or advanced directives.

3. Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.

4. Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.

5. Participate in care such as following the treatment plan established by the physician, including instructions of nurses and other health care professionals as they carry out the physician's orders.

6. Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses, and hospitalizations, all medication, including over the counter and dietary supplements, and unexpected changes in the patient's condition or any other patient health matters, including allergies and sensitivities.

7. Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed the patient forfeits the right to care at the facility and will be responsible for the outcomes.

8. Promptly fulfilling his or her financial obligation to the facility.

9. Payment to the facility for copies of medical records the patient may request, if applicable.

10. Identifying any patient safety concerns.

11. Accepting personal financial responsibilities for charges not covered by insurance.

12. Provide a responsible adult to transport him/her home from the facility.

All medical records will be kept until the patient is 23 years of age, plus 5 years, if currently less than 23 years of age; all other medical records will be kept at least 5 years.

I HAVE READ AND FULLY UNDERSTAND MY RESPONSIBILITIES AS A PATIENT

Patient/ Parent Signature _____ **Date** _____ **Time** _____

Witness Signature (IPSC STAFF) _____

Patient Label

Innovative Procedural and Surgical Center

P: (702) 998-7179
F: (702) 405-7676
PainFreeNevada.com

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE & INFECTION CONTROL NOTICE

I acknowledge that I have received the attached Privacy Notice & Infection Control Notice.

Signature Patient or Personal Representative **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for use or disclosure of protected health information

Innovative Procedural and Surgical Center is committed to HIPAA regulations. Therefore, each patient is required to sign a release. Patients may include companion(s), (family member(s), friends, etc.) accompanying them to their appointment, schedule or reschedule appointments. Listed individuals are approved to hear discussions regarding the patient's health information.

I authorize the following individuals to be involved in the discussion of my medical health information. I understand that I am responsible for the release of information provided by Innovative Procedural and Surgical Center to the following:

Name: Relationship:

Signature Patient or Personal Representative **Date**

RELEASE OF RECORDS

In an effort to provide continuity of care and best patient outcomes it is important and may be necessary to share relevant information regarding your care in the event of a hospital transfer or admission to another facility. In the event of a **hospital transfer** or issue related to **the current date of service:**

- I hereby authorize Innovative Procedural and Surgical Center to release the records to the receiving hospital or new admitting facility.
- **Please note, Innovative Procedural and Surgical Center will not release Protected Health Information to anyone not directly involved with your care.**
- I hereby authorize the receiving hospital, clinic, or physician's office to release the hospital discharge summary, **post office visit notes, lab and or studies** related to Innovative Procedural and Surgical Center.

Signature Patient or Personal Representative **Date**

Patient Label

Innovative Procedural and Surgical Center

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F: (702) 405-7676
PainFreeNevada.com

ADVANCED DIRECTIVES

Advanced Directives are a way for you to declare ahead of time how, and by whom, medical decisions will be made on your behalf, if the time comes when you can no longer communicate your wishes. The two most common forms of advanced directives are **Living Wills and Durable Power of Attorney for Health Care.**

- **Living Wills,** also known as Directive to Physicians, Declarations as to Medical/Surgical treatment or Declarations, allow you to specify ahead of time whether you want life-sustaining treatment begun or continued if you are unable to communicate your wishes

- **Durable Power of Attorney for Health Care or Health Care Proxy** allows you to appoint another person to act for you if you lose the ability to act for yourself.

Booklets about advanced Directives are available at IPSC at the admission desk. Please ask a staff member for one if you would like more information. Forms and additional information can be found at the Nevada Department of Health and Human services website: http://dhcfp.nv.gov/Resources/PI/AdvanceDirectives/

PATIENT DECLARATION

Do you have an Advanced Directive or Living Will? ☐ **YES** ☐ **NO**

Do you have a copy of your Advanced Directive or Living Will with you? ☐ **YES** ☐ **NO**

If yes, would you like us to put it in your chart? ☐ **YES** ☐ **NO**

ADVANCED DIRECTIVE POLICY

Policy: Innovative Procedural and Surgical Center recognizes the need for Advanced Directives in the hospital setting, it has been determined that due to the natures of all procedures, a patient's existing Advanced Directives will not be followed while the patient is at Innovative Procedural and Surgical Center. Full emergency procedures will be followed in response to any medical emergency. However, we will forward your Advanced Directives along with your medical records in the event that you are transferred to a hospital.

Patient Information Packet:

As required by the CMS (federal regulation), effective 5/18/2009; written and verbal notice regarding Patient's Rights and Responsibilities, Advanced Directives and corresponding policies, and a list of business owners are given prior to the date of service (DOS). **Please check 1 or 2 (whichever is applicable)**

1. I acknowledge receipt of the written and verbal notice described above.
   ☐ Prior to DOS ☐ with registration on DOS due to scheduling
2. ☐ Patient Information Packet was received and completed at a prior DOS with IPSC

By signing below, I acknowledge I have read and understood the above policy on Advanced Directive and have received the Patient Information Packet

Patient Signature _____ **Witness (IPSC STAFF)** _____ **Date** _____

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INFECTION CONTROL NOTICE

Developed in accordance with Senate Bill 339 and Chapter 439 of the Nevada Revised Statutes

FREQUENTLY ASKED QUESTIONS ABOUT FACILITY-ACQUIRED INFECTIONS/HEALTH CARE ACQUIRED INFECTIONS

A health care or facility-acquired infection is one that can occur while a patient receives care or treatment. It is an infection that first appears between 48 hours and four days after a patient receives treatment at a health care facility, such as an outpatient surgical center. These kinds of infections are often preventable.

You will notice the presence of infection prevention everywhere throughout our facility through the placement of:

- Hand sanitizer gels or rubs
- Hand washing stations
- Disinfecting wipes
- "Cover your Cough" signs
- Healthcare providers wearing gloves, masks, and gowns

There are recommendations that can help prevent infection at the time of your surgical procedure. These include:

***Handwashing:** It is the most important step in preventing infection. Our staff is trained at the beginning of their employment, and annually thereafter, on the importance of hand hygiene and other measures of preventing infection. We train based on effective and nationally recognized infection control policies.

***Skin Preparation:** Hair removal (if needed for the type of procedure you are having) will be done immediately prior to surgery and should not be done before. A healthcare provider will do this for you with electric clippers. The surgical area should not be shaved with a razor. Razors can cause small "nicks" in the skin through which bacteria can enter. Consult your doctor to see if he/she recommends using a chlorhexidine soap to shower or bathe with for three to five days prior to your surgery. There are various types that can be purchased without a prescription. It can help remove bacteria that you may be carrying on your skin.

***Antibiotics:** Antibiotics may be needed for your surgical procedure. If so, our goal is to give the appropriate antibiotic ordered by your physician to you within 60 minutes of the start of your surgery.

***Operating Room:** We limit personnel in the room to those who are directly involved in the procedure. We wear special covers, masks, gowns, and gloves during surgeries to keep the surgery area clean. The temperature of the OR will be maintained at a reasonable level. Infection risk is reduced when the body is kept warm, and we provide warm blankets and other warming measures to maintain your temperature as needed.

***Wound/ Dressing Care:** You will be provided with instructions on how to care for the surgical site and any dressings post-operatively. Your physician will let you know if there are any restrictions regarding showering or getting the surgical site wet.

***Diabetics:** Maintaining a normal blood glucose level is critical to wound healing and recovery from your surgical procedure. Elevated levels of blood sugar are linked to a higher risk of post-surgical infections. If you are diabetic, please make sure you tell the staff so that we can monitor your blood sugar throughout the pre-operative, operative and recovery phases of your procedure.

***Signs of infection:** If you have any of the following symptoms please call your doctor immediately- redness and pain at the surgery site, drainage of cloudy fluid, temperature 101 degrees Fahrenheit or higher, shaking chills.

- Health problems such as allergies, diabetes, and obesity, as well as low hematocrit levels can create an elevated risk of infection. Be sure to discuss these with your doctor.
- Stop Smoking well in advance of your surgery. Patients who smoke are three times more likely to develop an infection as nonsmokers and have a significantly slower recovery.
- After your surgical procedure friends and family should not touch your wound or dressings. They should also wash their hands before and after visiting with you.
- Please do not be shy about asking for more information about your care, and please speak up! If you do not see your providers clean their hands, please ask them to do so!
- If you are receiving an injection, ask if the needle, vial, and syringe have been newly opened for you.

For further information, including reporting of facility-acquired infections go to:

Nevada State Health Division, Bureau of Health Care Quality and Compliance
4220 South Maryland Parkway, Suite 810, Bldg. D Las Vegas, Nevada 89119
Phone: 702-486-6515 | Fax: 702-486-6520 | Email: BLCweb@health.nv.gov

If you have any additional questions, please ask your doctor or nurse. The infection rate for our facility is available to you upon request

PRIVACY NOTICES HIPAA FOR: INNOVATIVE PROCEDURAL AND SURGICAL CENTER

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information: The ISPC may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization, or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment: Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. To get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. Operations: We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the ISPC and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review, and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures: As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your surgery date, to inform you of potential treatment alternatives or options, to inform you of health-related benefits or services that may be of interest to you, or to contact you to raise funds for the facility or an institutional foundation related to the facility. If you do not wish to be contacted regarding fundraising, please contact our Privacy Officer.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object
Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for several reasons including the following:

A. When Legally Required: We will disclose your protected health information when we are required to do so by any federal, state, or local law.

B. When There Are Risks to Public Health: We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA-regulated products, enable product recalls, repairs, or replacements to the FDA and to conduct post-marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Suspended Abuse, Neglect or Domestic Violence: We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities: We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection with Judicial and Administrative Proceedings: We may disclose your protected health information during any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes: We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons, or similar process.
- For identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. To Coroners, Funeral Directors, and for Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

H. For Research Purposes: We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions: In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veteran's activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations

K. For Worker's Compensation: The facility may release your health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition, or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have acted in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information: You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the facility uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record.

B. The right to request a restriction on uses and disclosures of your protected health information: You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.
The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The right to request to receive confidential communications from us by alternative means or at an alternative location: You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. The right to request amendments to your protected health information: You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments

E. The right to receive an accounting: You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. Accounting requests may not be made for periods of time more than six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The right to obtain a paper copy of this notice: Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

VII. Complaints

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

Innovative Procedural and Surgical Center
9920 W. Cheyenne Ave, Suite 120
Las Vegas, NV 89129
ATTN: Privacy Officer
The Privacy Officer can be contacted by telephone at (702) 998-7179

IX. Effective Date: This Notice is effective July 29, 2011.