Thank you for choosing P&S Surgical Hospital! For your convenience, we have created much of this packet in an interactive online packet. Some of these forms will require Adobe Acrobat Reader to view, fill out, and eventually print. Reader is available for download on the Adobe Web Site: http://get.adobe.com/reader/

On the day of your procedure, please bring:

- the entire registration packet
- insurance cards
- a picture ID
- prescription bottles

If you have any questions, please do not hesitate to call us at 318-388-4040.

Sincerely,
P&S Surgical Hospital Staff

PATIENT INFORMATION FORM
TODAY'S DATE ___/___/___

PATIENT NAME ____ (________________)
LAST FIRST M.I. *preferred name*

ADDRESS ____
STREET CITY STATE ZIP

_______-_____-_______ ______/______/_______ (_____)_____-_______ (_____)_____-______
SOCIAL SECURITY # DATE OF BIRTH HOME PHONE CELL PHONE

EMPLOYER____ (____)____-_____
WORK PHONE

MARITAL STATUS: □MARRIED □SINGLE □DIVORCED □WIDOWED
FULLTIME STUDENT: □YES □NO

PRIMARY INSURANCE
INSURED'S NAME ____
LAST FIRST M.I.
RELATIONSHIP TO PATIENT______________________________

ADDRESS ____
STREET CITY STATE ZIP

_______-_____-_______ ______/______/_______ (_____)_____-_______ (_____)_____-______
SOCIAL SECURITY # DATE OF BIRTH HOME PHONE CELL PHONE

EMPLOYER____ (____)____-_____
WORK PHONE
INSURANCE CARRIER__________________________________EFFECTIVE DATE____________
POLICY #________________________________GROUP #__________________________

SECONDARY INSURANCE
INSURED'S NAME ____
LAST FIRST M.I.
RELATIONSHIP TO PATIENT______________________________
INSURANCE CARRIER__________________________________EFFECTIVE DATE____________
POLICY #________________________________GROUP #__________________________

COMMUNICATIONS REGARDING MY ACCOUNT:
Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages and other forms of communications.

____ ____________________
Patient or Responsible Party's Signature Date
If not Patient, relationship to patient ________________________
Revised 10/2011

PATIENT STICKER

CONSENT TO OPERATION AND THE RENDERING OF OTHER MEDICAL TREATMENT AND SERVICES TO ALL PATIENTS INCLUDING MINORS

I, ______________________________, applying for admission of (Patient/Responsible Party if Patient is a Minor) _________________________ (hereinafter called "patient"), (Patient's Name if a Minor, or "Myself") to P&S Surgical Hospital, do hereby authorize and direct that the hospital or any member of its staff or employees and my physician to provide such medical services to patient as he/she or they may deem reasonable and necessary to treat patient for any illness, condition or disease with which patient is or may be afflicted.

□ I consent to treatment provided by students under the supervision of appropriately licensed personnel. _____________ Patient Initials

□ I consent to have other observers (job shadowing, volunteers) present during my treatment. _____________ Patient Initials

I realize that this medical treatment will consist of diagnostic and therapeutic treatment that may include but is not limited to diagnostic radiology and laboratory examinations, administration of therapeutic drugs and fluids, administration of anesthesia, routine venipuncture, and other such diagnostic and therapeutic treatment that may be necessary and required as ordered by a physician.

I also understand that some services may be performed by personnel acting under the terms and limitations of service contracts (i.e. St. Francis Medical Center, United Home Care, City Apothecary, etc.) with P&S Surgical Hospital.

I further authorize the release of my medical records to my family physician.

______________________________ Signature of Patient or Representative

______________ Date

______________________________ Relationship to patient (if party other than patient)

______________________________ Witness Signature

______________ Date

1. I have received written information about my rights and responsibilities as a patient (i.e. advance directives, privacy, informed consent, etc.) That information along with this form represents my understanding that I have the right to accept or refuse treatment. I have been informed that P&S Surgical Hospital will provide appropriate assistance for hearing impaired or visually impaired patients to assist with accessing care. I am also informed that I have a right to make an Advance Directive, which includes a Living will and/or Durable Power of Attorney for Healthcare, in accordance with Louisiana Law and P&S Surgical Hospital policies.

2. I hereby acknowledge receipt of the P&S Patient Information Booklet.

_____ I do **NOT** have a Living Will/Advance Directive.
______I do **NOT** have a Durable Power of Attorney for healthcare decisions, nor do I wish to create one.
_____ I do have a Living Will/Advance Directive. It is located at/with _________________________________.
Copy provided to P&S: ____ Yes _____ No

If Yes to Living Will and/or Advance Directive, please check all that apply:
______I am not able to bring these to P&S Surgical Hospital and would like to execute a new one.
______I do not have these with me but would like for P&S Surgical Hospital to obtain for my medical record.
______I would like to create a Living Will or Durable Power of Attorney

______________________________ Patient or Responsible Party

______________ Date

Revised 6/2013

PATIENT STICKER

ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING OF THE NOTICE OF HEALTH INFORMATION PRACTICES

I have received a copy of the **Notice of Health Information Practices at P&S Surgical Hospital**. I understand the contents and purpose of my health information recorded at **P&S Surgical Hospital**. I also understand my rights as a patient as outlined in the notice.

I further acknowledge that I have read the **Notice of Health Information Practices at P&S Surgical Hospital** and understand the different types of disclosures of my health information that may legally be made. I understand that if I wish to restrict these disclosures in any way I must complete a Request for Restriction form and return it to the Privacy Officer at P & S Surgical Hospital. I otherwise acknowledge and consent to disclosures of my health information as identified in the **Notice of Health Information Practices at P&S Surgical Hospital.**

I have received a copy of **P&S Surgical Hospital's** *Privacy Acknowledgement* which provides detailed information about how **P&S Surgical Hospital** may use and disclose my protected health information. By agreeing to the terms provided therein, I consent to my protected health information being shared with the **Louisiana Health Information Exchange (LaHIE).** This will allow **all** medical records from the encounter at **P&S Surgical Hospital** and **all** previous encounters at other facilities to be sent to **LaHIE.** This information will then be used in an effort to continue improving the quality and effectivess of the healthcare and service we provide. I have the right to restrict this disclosure to **LaHIE** by completing a Request for Restriction form.

____________________________________ __________________________
Signature of Patient/Legal Representative Date

If Individual Other than Patient, Relationship to Patient ________________________________

____________________________________ __________________________
Witness Date

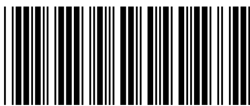
WHILE YOU ARE IN THE HOSPITAL

To whom do you wish us to communicate information about your condition during or after your surgery?
Please list names: ____

Please list the names of any individuals you do **NOT** wish for us to communicate any information about your condition at any time during your hospital stay: ____

______________________________________ ______________________________
Patient or Responsible Party Date

Revised 1/30/14



PATIENT STICKER

Consent for Release of Medical Information

In an effort to reduce healthcare costs to you and your insurance company, we need to obtain copies of any recent diagnostic tests you may have had.

Have you had:

lab work in the last 2 weeks? Yes No
If yes, where was it done? ____

an EKG in the last 6 months? Yes No
If yes, where was it done? ____

a chest xray in the last 6 months? Yes No
If yes, where was it done? ____

If you have answered "yes" to any of the above, please complete the following:
I, ____ authorize ____ to release copies of my medical records to P&S Surgical Hospital for the purpose of preoperative evaluation.

____ ________________________________
Patient or Responsible Party ***Date***

*If Responsible Party, relationship to Patient*____

Patient's date of birth____

Witness ____

Revised 10/2011

NOTICE TO PATIENTS

As a prospective patient of P&S Surgical Hospital, we are pleased to inform you of the following:

DISCLOSURE OF PHYSICIAN OWNERSHIP

1. P&S Surgical Hospital (the "Hospital") is partly owned by physicians and meets the federal definition of a physician owned hospital as specified in 42 CFR 489.3. A list of the Hospital's physician owners is available upon request. The hospital is also partly owned by St. Francis Medical Center.
2. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than P&S Surgical Hospital.
3. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

DISCLOSURE OF EMERGENCY RESPONSE PLAN

1. P&S Surgical Hospital has one or more physicians available to respond to medical emergencies during most hours of operation; however, we cannot guarantee that a physician will be present at the Hospital at all times. The Hospital has a contract with St. Francis Medical Center hospitalists (physicians trained in critical care medicine) to ensure that qualified and properly trained medical personnel are available to respond to any medical emergency that may arise when a physician is not present on-site at the Hospital. The SFMC hospitalists are available on-site at SFMC (located directly across the crosswalk from P&S) 24 hours per day/7 days per week.
2. P&S Surgical Hospital is prepared to provide resuscitation and other basic life-saving measures at all times. All P&S Registered Nurses are certified in ACLS (Advance Cardiac Life Support); those taking care of pediatric patients are also certified in PALS (Pediatric Advance Life Support). There are two employees on site at all times. A registered nurse is available on site at all times.
3. Should you develop a medical emergency, the P&S staff will take the following measures:
   - Immediately initiate life-saving treatment
   - The SFMC hospitalists as well as your admitting physician will be notified immediately.
   - If necessary, the hospital will transfer the patient to St. Francis Medical Center, a facility that is staffed with on-site physicians 24 hours a day, 7 days a week. P&S has transfer agreements with St. Francis Medical Center and Glenwood Regional Medical Center. Patients transferred to St. Francis will be transported via stretcher, across the crosswalk. Patients transferred to Glenwood will be transferred via ambulance.

If you would like additional information about P&S Surgical Hospital's capabilities for handling medical emergencies please contact Administration at 388-4040.

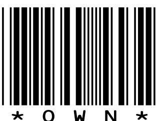
By signing this Acknowledgment of Disclosure, you acknowledge that you have read and understand the foregoing Notice to Patients regarding physician ownership and patient safety measures.

____ ___________________________

PRINT: Name of Patient Date

____

SIGNATURE OF PATIENT or Responsible Party (If Responsible Party, relationship to patient ______________________________)



SEPARATE BILLING FOR PROFESSIONAL SERVICES

"NOTICE

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN". FOR A LIST OF P&S PROVIDERS PLEASE VISIT OUR WEBSITE AT (*www.pssurgery.com*)*, OR A LIST WILL BE PROVIDED TO YOU UPON REQUEST.*

PATIENTS WHO ARE SEEN AT P&S SURGICAL HOSPITAL FOR LAB TESTING, RADIOLOGY (X-RAY), LITHOTRIPSIES OR RECEIVE ANESTHESIA WILL ALSO RECIEVE A SEPARATE BILL FROM THE PHYSICIAN OR SPECIALIST PERFORMING SERVICES OR INTERPRETING THE STUDY.

PLEASE CALL THE NUMBERS LISTED BELOW FOR BILLING QUESTIONS FOR ANY OF THE FOLLOWING MEDICAL GROUPS.

ANESTHESIA
SMSO
PO BOX 3185
MONROE, LA 71210
318-998-6138

PATHOLOGY
DELTA PATHOLOGY GROUP,LLC
309 JACKSON STREET
MONROE, LA 71201
318-841-9526

BAYOU PATHOLOGY
109 CIRCLE DRIVE
WEST MONROE, LA 71292
318-323-1834

Lithotripsy
Healthtronics Inc.
DALLAS, TX 75284
866-314-4242

Hospitalist
SAINT FRANCIS MEDICAL CENTER
309 JACKSON STREET
MONROE, LA 71201
318-966-4000

RADIOLOGY
Management Services Network, LLC
717 20th street
Columbus, Georgia 31904
800-841-4236

Patient or Guarantor Signature *Date*

Witness

Revised 07/01/2012

PATIENT STICKER

TRANSFUSION OF BLOOD PRODUCTS

During my hospitalization, there is a possibility that my physician may deem it necessary due to my medical condition to order blood or blood components. The chances for my improvement or recovery will be significantly helped by receiving blood products by transfusion, such as packed red blood cells, fresh frozen plasma, platelets, or cryoprecipitate.

The most common side effects from blood product transfusion are allergic type reactions such as hives and itching; some recipients experience fever. Usually these types of reactions subside on their own or are easily treated, many times not even requiring the transfusion to be stopped.

Because blood donors are screened and all blood is tested in accordance with strict scientific rules established by the American Association of Blood Banks (AABB), blood transfusions are considered quite safe; however, I understand that even with testing by the most up-to-date methods, there is a small chance the blood products may contain a virus; the risk of that happening is usually less than 1 in a million.

I have had an opportunity to ask questions regarding transfusion of blood products.

□ **I permit** blood or blood components transfusions. I agree this Informed Consent may serve as consent to additional blood products as deemed necessary by my physician for the duration of my hospitalization.

□ **I refuse to permit** blood or blood components transfusions. I hereby release the organization, its personnel and physicians from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives.

____ ___________________________

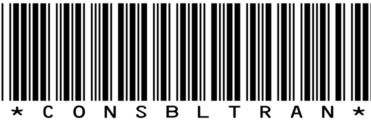
Patient or Responsible Party Date

If Responsible Party, relationship to Patient _______________________________________

____ ___________________________

Witness Date

Revised 10/2011



PATIENT MEDICAL HISTORY

HT:______________ WT:_______________ ALLERGIES:____

DO YOU WEAR: GLASSES CONTACT LENSES HEARING AIDS DENTURES

***PLEASE CIRCLE ALL THAT APPLY TO YOU:**

RESPIRATORY

*ASBESTOS
*ASTHMA
*BRONCHITIS
*COPD
*EMPHYSEMA
*PNEUMONIA
*SHORTNESS OF BREATH
*SLEEP APNEA/ USE A CPAP MACHINE
*TOBACCO (SMOKELESS)
*TUBERCULOSIS
*SMOKER (# OF CIGS/DAY___________)
DATE QUIT:_____________________________.

I WOULD LIKE INFO ON HOW TO STOP SMOKING_____

CARDIOVASCULAR

*ABNORMAL EKG
*ANGINA (CHEST PAIN)
*BLOOD CLOTS/ DEEP VEIN THROMBOSIS (DVT)
*BLOOD PRESSURE ISSUES: H=HIGH L=LOW
*CORONARY ARTERY BYPASS GRAFT (CABG)
*CORONARY ARTERY DISEASE
*DEFIBRILLATOR
*HEART ATTACK DATE:____
*HEART FAILURE: RIGHT SIL HEART FAILURE(CHF)
*MURMUR
*STENT/ DATE:_____________________________
*VALVE DISEASE

HEART DOCTOR_______

GENITOURINARY

*DIALYSIS: MWF, TTS, PERITONEAL (PD)
*PROSTATE DISEASE
*RENAL FAILURE/END STAGE RENAL DISEASE (ESRD)
*URINARY RETENTION
*URINARY TRACT INFECTION (UTI)

KIDNEY DOCTOR____________________________

NEURO/MUSCULOSKELETAL

*ARTHRITIS/DEGENERATIVE JOINT DISEASE (DJD)
*BACK PROBLEMS
*STROKE/CARDIOVASCULAR ACCIDENT (CVA)/TIA
*HEADACHES/MIGRAINES
*↑INTRACRANIAL PRESSURE (ICP)
*LOSS OF CONSCIOUSNESS (LOC)/FAINTING
*MUSCLE WEAKNESS/PARALYSIS
*SEIZURES
*SHUNT

HEPATO/GASTROINTESTINAL

*ACID REFLUX
* ALCOHOL (# OF DRINKS/WEEK__________)
* BOWEL OBSTRUCTION
* CIRRHOSIS
*HERNIA, TYPE:__________________________
* JAUNDICE/HEPATITIS, TYPE:__________________________
* NAUSEA/VOMITING
* ULCER, TYPE:___________________________

PRIMARY DOCTOR______________________

ENDOCRINE

*DIABETES (D=DIET CONTROLLED, I=INSULIN, O=ORAL MEDS)
*THYROID DISEASE: ↑=HYPER, ↓=HYPO, G=GOITER

OTHER

*ABNORMAL BLEEDING/HEMOPHILIA
*ANEMIA
*CANCER, TYPE:_____________________________
*CHEMOTHERAPY
*DECUBITOUS ULCERS/SKIN ABNORMALITIES
* DEHYDRATION
*IMMUNOSUPPRESSED
*MALIGNANT HYPERTHERMIA
*MRSA/OTHER STAPH INFECTION
*SICKLE CELL: C=CARRIER T=TRAIT
*STEROID USE (RECENT)
* TRANSFUSION OF BLOOD PRODUCTS

PATIENT SURGICAL HISTORY

SURGERY	DATE (estimate if unsure)	LAPAROSCOPIC VS OPEN (if applicable)
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

*** IF ELIGIBLE, I WOULD LIKE TO RECEIVE A FLU VACCINE WHILE I AM ADMITTED AT P&S (OCTOBER-MARCH ONLY) ________**

*** IF ELIGIBLE, I WOULD LIKE TO RECEIVE A PNEUMONIA VACCINE WHILE I AM ADMITTED AT P&S________**

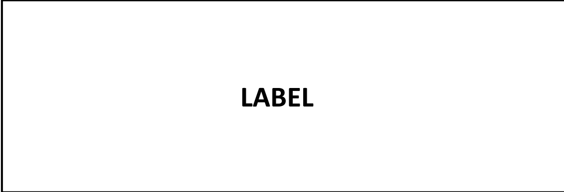
FAMILY MEDICAL HISTORY

***PLEASE INDICATE ANY FAMILY MEMBER(S) WHO HAVE A HISTORY OF THE FOLLOWING:**

DISEASE PROCESS	FAMILY MEMBER(S)
1) DIABETES (D=DIET CONTROLLED, I=INSULIN, O=ORAL MEDS)	______________________
2) CANCER, TYPE:_________________________	______________________
3) BLOOD PRESSURE ISSUES: H=HIGH L=LOW	______________________
4) CARDIOVASCULAR ISSUES	______________________
5) MALIGNANT HYPERTHERMIA	______________________
6) PSEUDOCHOLINESTERASE DEFICIENCY	______________________

Revised Sept. 2014

SMSO ANESTHESIA, LLC
ROSEMARY STAGE, MD
BRIAN JOHNSON, MD
RUSHTON JONES, MD
WAYNE THIBODEAUX, MD
P O BOX 3185
MONROE, LA 71210



AUTHORIZATION FOR RELEASE OF INFORMATION

For the purpose of reimbursement of fees for professional services rendered by SMSO ANESTHESIA, LLC, I authorize the release of any necessary information to third party payors, insurance companies, attorneys, or other relevant parties to ensure payment for such services. Information provided by me regarding health care coverage is true and accurate to the best of my knowledge.

ASSIGNMENT OF BENEFITS

For services rendered, I hereby authorize my insurance company to assign and transfer any benefits due me to be paid directly to SMSO ANESTHESIA, LLC. It is agreed that payment to SMSO ANESTHESIA, LLC pursuant to this authorization, by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this agreement.

FINANCIAL UNDERSTANDING AND GUARANTEE OF PAYMENT

I understand that services rendered by SMSO ANESTHESIA, LLC will require payment, and I acknowledge complete responsibility for such payment. I hereby obligate myself to pay the account of SMSO ANESTHESIA, LLC in accordance with the regular rates and terms of such payment within 60 days from the date of service rendered and my insurance has not paid, I will be responsible for all balances due. I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, co-insurance and non-covered services. Should the account be turned in to an attorney or licensed collection agency for collections, I agree to pay reasonable attorney's fee and other collection costs. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communication. **REMINDER:** Quoted charges prior to surgery are estimates only; actual anesthesia charges can't be calculated until after the surgery is completed.

CREDIT BALANCE

I hereby authorize SMSO ANESTHESIA, LLC to transfer any overpayment on my anesthesia account to any outstanding balance on my P&S Surgical Hospital Accounts. If all accounts on SMSO Anesthesia, LLC and P&S Surgical Hospital are paid in full – any overpayments will be paid directly to me.

COMMUNICATIONS REGARDING MY ACOUNTS

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

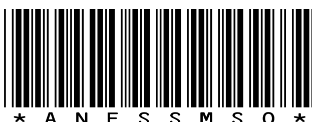
____ ________________

Signature of Patient or Responsible Party & Relationship (*If patient is a minor or unable to sign)* Date

____ ________________

Witness Date

Revised 10/20/14



Name:	Primary Doctor:
Pharmacy:	Pharmacy Phone # :

Allergy	Reaction	Allergy	Reaction
1		4	
2		5	
3		6	

Weight:__________________lb

Height:_________ft_________in

Patient's Home Medications:

Medication List the names of any medications you are taking, including any over the counter medicines (including vitamins, minerals, and herbal supplements).	**Strength** List the strength of the medicine (milligrams, units, tsps, drops, etc.)	**Dose** How much do you take (# of tablets, capsule, units, etc.)	**Frequency** How often do you take the medicine 1) everyday 2) as needed 3) AM 4) PM 5) how many times a day	**Route** How do you take the medicine (by mouth, injection, patch, drops, etc.)	**Reason For Taking**	**Special Instructions** With food, on an empty stomach, stop taking 5 days before surgery, etc.)	**Last Dose Taken** To be filled in on the day of surgery
Example: ***Furosemide***	*40mg*	*2 tablets = 80mg*	Everyday in the morning, one time/day	*By mouth*	"To get the fluid off of my heart."	Do not take this medication the day of surgery	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Preferred contact method(s): Phone #___________________

Text: ___________________

E-mail: ____

-

Allergy Information/Medications (Continued)

Allergies	Reaction	Allergies	Reaction
7		10	
8		11	
9		12	

Medication	Strength	Dose	Frequency	Route	Reason for Taking	Special Instructions	Last dose Taken
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							