

# PATIENT APPOINTMENT INFORMATION

## Bring to the Surgery Center

The envelope you were given at your pre-op appointment.

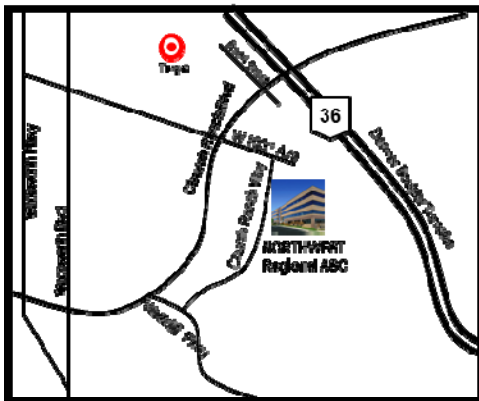
Driver's license, photo ID, insurance card and co-pay (if applicable).



Arriving at  
NWR  
Surgery  
Center

When you arrive at the surgery center, enter through the front door of the 4-story brick building. The surgery center is at the back of the lobby.

Please check in at the front desk. You will be brought to the pre-op area where your nurse will prepare you for the procedure.



### Traveling from Boulder/Longmont:

Take US-36 to Church Ranch Blvd/104th Ave exit (Westminster). Turn right onto Church Ranch Blvd. Turn left at the second light onto 103rd. (There is a First Tier Bank on the corner). At the next corner, turn right onto North Church Ranch Way. We are in the 4-story brick building on your left.

### Traveling from Denver:

Take US-36 to Church Ranch Blvd/104th Ave exit (Westminster). Turn left onto overpass which is Church Ranch Blvd. Turn left at the second light onto 103rd. (There is a First Tier Bank on the corner). At the next corner, turn right onto North Church Ranch Way. We are in the 4-story brick building on your left.

## Preparing for your Procedure

Please follow these instructions:

- **Do not** eat or drink anything after midnight on the day before your procedure.
- Please leave valuables such as jewelry at home. Remove all piercings.
- Remove contacts, wear your glasses.
- Discontinue all anticoagulant medications (Aspirin, Coumadin, Heparin and Plavix) per your physician's orders.
- If applicable, ask your physician how to adjust your diabetes and/or blood pressure medication prior to procedure.
- You **may not** return to work on the day of the procedure.
- **You must have someone drive you home** and stay with you for at least 12 hours following the procedure. Taxi cabs can be used only if you have someone in addition to the driver accompany you.

The NWR staff will call you 1 day before your procedure to obtain your medical history and to confirm the scheduled date and time of arrival.

## On the day of your Procedure

- **Do not** eat or drink anything on the morning of procedure.
- Take only essential medication with a small sip of water on the morning of the procedure.
- Shower or bathe on the morning of your procedure. Wear loose-fitting clothing.
- No lotions, make-up or perfumes.

Please be sure to arrive at the surgery center 1 hour before your surgery time.

## After your Procedure

After the procedure, you will be taken to the recovery room where the nurses will make your recovery as comfortable as possible. You may experience some normal side effects of anesthesia.

Once you have fully recovered and you are ready for discharge, one of the nurses will escort you to your vehicle. Please remember to have a driver available to bring you home safely.

## Insurance and billing

Please bring your insurance card and driver's license.

Self pay patients will be required to pay for services at registration. Mastercard, Visa, American Express and Discover are accepted.

Patients with verified insurance will be required to pay their co-pay on the day of procedure. As a courtesy, NWR will bill your insurance on your behalf.

In the event that any of the above requirements cannot be met, we will attempt to make other financial arrangements. These arrangements must be made prior to admission and must be approved by the Business Office Manager.

## PATIENT RIGHTS & RESPONSIBILITIES

**The facility observes and respects a patient's rights and responsibilities without regard to race, color, national origin, culture, disability, age, personal values and religion or belief system.**

### **The patient has the right to:**

- Receive the care necessary to help regain or maintain his or her maximum state of health, and if necessary, cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of service.
- Expect full recognition of individuality, including personal privacy in treatment and care. In addition, all communications and records will be kept confidential.
- Complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment and procedure.
- Be fully informed of the scope of services available at the facility, provisions for after-hours and emergency care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If a 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.
- Make informed decisions regarding his or her care.
- 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 or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another facility, or as required by law or third party payment contractor.
- Be informed of any human experimentation or other research/educational projects affecting the care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and questions at any time.
- Assistance in changing primary or specialty physicians or dentist if other qualified physicians or dentists are available.
- Provide patient access to and/or copies of his or her individual medical records.
- Be informed of the facility's policy regarding advance directives/living wills.
- Be fully informed before any transfer to another facility or organization to ensure the receiving facility has accepted the patient transfer.
- Be free from all forms of abuse and harassment.
- Express those spiritual beliefs and cultural practices that do no harm or interfere with the planned course of medical therapy for the patient.
- Expect the facility to agree to comply with Federal Civil Rights laws that assure it will provide interpretation for individuals who are not proficient in English. The facility presents information in the manner and form, such as TDD, large print materials, Braille, audio tapes and interpreters, that can be understood by hearing and sight impaired individuals.
- Have an initial assessment and regular reassessment of pain.
- Education of patients and families, when appropriate, regarding their roles in managing pain, as well as potential limitations and side effects of pain treatment, if applicable.
- Have their personal, cultural, spiritual, and/or ethnic beliefs considered when communicating to them and their families about pain management and their overall care.

### **The patient is responsible for:**

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respect the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
- Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Promptly fulfilling his or her financial obligations to the facility.
- Payment to the facility for copies of the medical records the patient may request.
- Identify any patient safety concerns.

## NOTICE REGARDING ADVANCE DIRECTIVE POLICY

The Center requires the following notice to be signed by each patient in order to be in compliance with the Patient Self-Determination Act and State law.

An Advance Directive is a document or documentation allowing a person to give direction about future medical care or to designate another person to make medical decisions if the individual loses decision-making capability. Patients are not required to have an Advance Directive in order to receive treatment at the Center.

There are many types of Advance Directions, but the two most common forms are:

**Living Wills**—instructions explaining wishes regarding health care should the individual be unable to make decisions.

**Durable Power of Attorney**—a signed, dated, and witnessed document naming another person as an individual’s agent or proxy to make medical decisions for that individual should they become unable to make decisions.

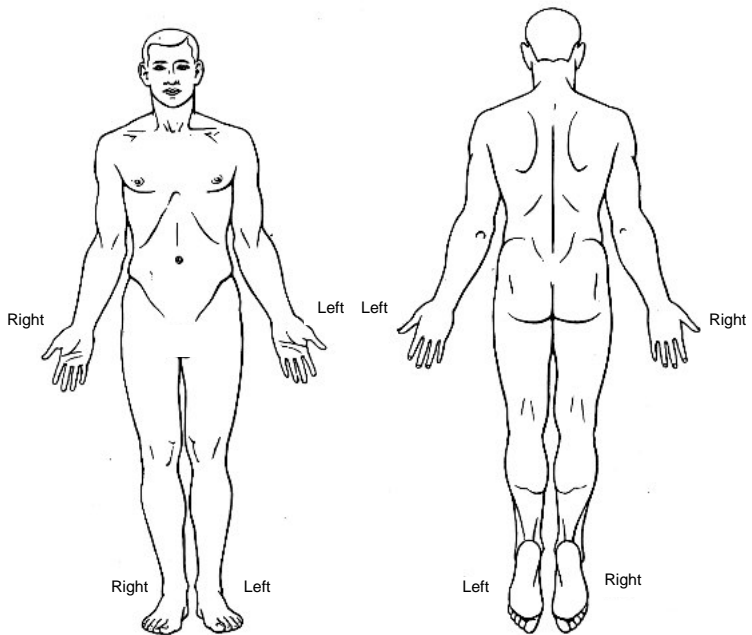
The type of Advance Directive that may apply to the center are called “requests to forego resuscitative measures” or “do not resuscitate orders (collectively referred to as a DNR)”. A DNR order is typically used by terminally ill patients who do not want to be resuscitated should they suffer a cardiac or respiratory arrest or other life-threatening situation.

The center is an outpatient facility, where only elective surgery and/or procedures are performed. If a patient should suffer a cardiac or respiratory arrest, or other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed advance directives.

## DISCLOSURE OF OWNERSHIP

Titan Health Corporation  
Christopher Centeno, M.D.  
John Schultz, M.D.  
Daniel Bennett, M.D.  
Bradley Vilims, M.D.  
Scott Brandt, M.D.  
Melody Denham, M.D.

**PRE-INJECTION PAIN ASSESSMENT**

<b>WHO REFERRED YOU TO US?</b>	<b>INTENSITY OF PAIN</b> (please circle the # that best describes your pain) Right now 0 1 2 3 4 5 6 7 8 9 10 <b>On this diagram, please shade the areas where you feel pain.</b>		
<b>REASON FOR TODAY'S VISIT</b> (indicate area to be treated / procedure to be done today)			
<b>DURATION OF PAIN WE ARE TREATING TODAY?</b>			
<b>HOW DID THE PAIN BEGIN?</b> <input type="radio"/> Suddenly date: _____ <input type="radio"/> Gradually			
<b>DESCRIBE THE LOCATION AND MOVEMENT OF YOUR PAIN</b> Starts where? Travels to? % Back/Buttocks _____ % Legs _____ % Neck/Shoulder _____ % Arms _____ % Other _____			
<b>DESCRIBE THE QUALITY OF YOUR PAIN</b> <input type="radio"/> Achy <input type="radio"/> Stabbing <input type="radio"/> Throbbing <input type="radio"/> Cruel <input type="radio"/> Torturing <input type="radio"/> Burning <input type="radio"/> Penetrating <input type="radio"/> Shooting <input type="radio"/> Cramping <input type="radio"/> Sharp <input type="radio"/> Dull <input type="radio"/> Tender			
<b>WHAT MAKES THE PAIN BETTER</b> <input type="radio"/> Laying down <input type="radio"/> Standing <input type="radio"/> Bending <input type="radio"/> Sitting <input type="radio"/> Walking	<b>CONSERVATIVE THERAPIES TRIED</b> <input type="radio"/> None <input type="radio"/> Physical Therapy <input type="radio"/> Chiropractic <input type="radio"/> Massage <input type="radio"/> Acupuncture <input type="radio"/> Behavior Therapy <input type="radio"/> Rest <input type="radio"/> Exercise		
<b>WHAT MAKES THE PAIN WORSE?</b> <input type="radio"/> Laying down <input type="radio"/> Standing <input type="radio"/> Bending <input type="radio"/> Sitting <input type="radio"/> Walking	<b>DIAGNOSTIC STUDIES PERFORMED</b> <input type="radio"/> MRI                                When _____ area _____ <input type="radio"/> CT Scan                              When _____ area _____ <input type="radio"/> X-Rays                                When _____ area _____		
<b>IS YOUR PAIN</b> <input type="radio"/> Worse in the morning <input type="radio"/> Worse as the day goes on <input type="radio"/> Other	<b>PREVIOUS PAIN INJECTIONS</b> <input type="radio"/> NONE Type: When: Who performed?		
<b>WORK STATUS</b> <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Not Working	<b>PREVIOUS PAIN RELATED SURGERY</b> <input type="radio"/> NONE Type: When: Who performed?		
<b>HOW DO YOU SLEEP?</b>	<b>HAVE YOU SEEN A SPINE SURGEON?</b> <input type="radio"/> No <input type="radio"/> Yes Name:		
<b>WHO WILL BE DRIVING YOU HOME?</b> Name: _____ Phone: _____ Will he/she be waiting? <input type="radio"/> No <input type="radio"/> Yes	<b>PATIENT SIGNATURE:</b>		
This area to be filled out by Staff only			
<b>PROCEDURE PERFORMED:</b>	<b>PATIENT LABEL</b>		
<b>POST-INJECTION EVALUATION</b>			
Time	% Improved	NPS (/10)	Description
15 Min	%	/10	
	%	/10	
	%	/10	
Discharge	%	/10	

PACU Nurse Signature: \_\_\_\_\_

## MEDICAL HISTORY

Name: \_\_\_\_\_

Sex F M

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**MEDICAL HISTORY: Do you now have or ever had:**

	Yes	No		Yes	No
<b>Asthma / Bronchitis / Emphysema / Shortness of Breath / COPD</b>			<b>Cancer</b> <i>Type: _____ Tx: _____ when: _____</i>		
<b>Sleep Apnea / C-PAP / Oxygen</b>			<b>Stroke / TIA / Rind</b> <i>When? _____ Weakness/deficit: _____</i>		
<b>Tuberculosis or exposure</b>			<b>Alzheimer's Disease / Dementia</b> <i>When diagnosed? _____</i>		
<b>High Blood Pressure</b> <i>years: _____</i>			<b>HIV / AIDS or Exposure</b> <i>describe: _____</i>		
<b>Chest Pain (Angina)</b>			<b>RSD / Chronic Pain</b>		
<b>Heart Attack(s) Stents placed</b>			<b>Any unusual or severe reaction to Anesthesia by your or family?</b>		
<b>Heart Murmur / Valve Problems / MVP</b>			<b>Depression / Anxiety (Panic Attacks)</b> <i>Treatment: _____</i>		
<b>Heart Failure / CHF / Ankle Swelling</b>			<b>Any Other Psychiatric History?</b> <i>(Personality disorders, bipolar, Schizophrenia, eat disorders, PTSD, etc.)</i>		
<b>Palpitations / Irregular Heartbeats</b>			<b>Any Suicidal or Homicidal thoughts or actions in the last month?</b> <i>Describe: _____</i>		
<b>Cardiac Pacemaker / Defibrillator</b> <i>Type: _____ when inserted? _____ Why? _____</i>			<b>Any diet pills or herbal preparation in the last month?</b> <i>What &amp; when? _____</i>		
<b>Thyroid Problems</b> <i>Low or high? _____</i>			<b>Aspirin, Aspirin containing meds, or NSAIDs in last week?</b>		
<b>Diabetes</b> <i>Years: _____ Insulin dep? _____ Gluc Readings: _____</i>			<b>Do you smoke or use tobacco?</b> <i>How much? _____ Years: _____</i>		
<b>Bleeding or Clotting Disorders:</b> <i>On Coumadin / Plavix? _____</i>			<b>Do you drink alcohol?</b> <i>How much? _____ Years: _____</i>		
<b>Arthritis</b> <i>Type: _____ where? _____</i>			<b>History of any drug or alcohol addiction?</b> <i>Describe and any treatments: _____</i>		
<b>Kidney / Bladder Problems</b>			<b>Anemia</b> <i>Type: _____</i>		
<b>Stomach / Bowel / Ulcer Problems / Reflux or GERD</b>			<b>Any street, recreational or illegal drugs?</b> <i>What &amp; how much? _____</i>		
<b>Hepatitis / Jaundice / Liver Disease</b> <i>Type: A B C when? _____</i>			<b>Have you taken steroids in the last 6 months?</b> <i>How much &amp; how long? _____</i>		
<b>Epilepsy / Seizures / Parkinson's / MS / Neurological Problems?</b> <i>Explain: _____</i>			<b>Treated for any active infection in the last month?</b> <i>Describe: _____</i>		
<b>Any Hearing Aid / Dentures / Glasses or Contacts in?</b>			<b>Work status:</b> full-time part-time unemployed retired <i>Work: _____</i>		
<b>Any metal in your body?</b> <i>What/where: _____</i>			<b>Have you ever been diagnosed or treated for MRSA infection?</b>		
<b>Describe / Notes:</b>					

Previous Operations	Year	Reason
1.		
2.		
3.		
4.		
5.		

**MEDICATIONS**

 Drug allergies  Yes  No To what? \_\_\_\_\_

Type of reaction \_\_\_\_\_

 Any other allergies?  Yes  No Explain \_\_\_\_\_

**PRESENT MEDICATIONS** (list any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

(WOMAN ONLY)					
	Yes	No		Yes	No
Are you pregnant or is there any chance whatsoever that you are pregnant?			Have you had a period in the last 6 months? If yes: date of last period: _____ If no: <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Menopause <input type="checkbox"/> Tubal Ligation		

 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician Initials \_\_\_\_\_

Patient Name (Printed) \_\_\_\_\_

Reviewed by \_\_\_\_\_

Reviewed by \_\_\_\_\_