

Please read these instructions and be sure to follow them carefully to avoid cancellation of your surgery:

If you have any questions, feel free to call our office at 470-297-0257. Our surgery center is located at 4150 Deputy Bill Cantrell Memorial Rd. Suite #160. (Behind Belk off exit 14, Ga 400)

- 1. Make arrangements to have a responsible adult be with you to drive you home after surgery. You must have an adult stay with you for the first 24 hours after your surgery. A parent or legal guardian <u>must</u> accompanya minor.
- 2. A nurse from the surgery center will contact you the week before surgery for your arrival time. For the safety of our employees, the door of the surgery center will not be unlocked until 6:30 am. Due to limited space, please limit family to two (2) people.
- 3. Adults- Do not eat anything (not even candy, gum, or mints) for at least eight (8) hours before your arrival time at the surgery center.
- 4. If you routinely take prescription medications, you may do so with a small sip of water up until three (3) hours prior to your arrival time, unless you have been directed otherwise by your surgeon or anesthesiologist.
- 5. Do not wear any make-up, nail polish, hairpins or jewelry to the surgery center. Do not bring money or valuables.
- 6. Shower or bathe the night before or the morning of surgery. Do not use lotions or oils on the skin the night before or the morning of surgery. Deodorant is permitted.
- 7. Notify the surgeon of any change in your physical condition (fever, cold, sore throat, etc.) before the surgery.
- 8. Wear loose comfortable clothing and shoes that slip on easily. No jeans, pantyhose, high heels or boots. Do not wear contact lenses.
- 9. Please do <u>not</u> take any aspirin products (Advil, Motrin, Aleve, Goody powders, etc.) as well as herbs and vitamins two (2) weeks prior to your surgery date.
- 10. An anesthesiologist will talk to you on the day of your surgery and answer any questions you may have regarding anesthesia.
- 11. Please call your insurance company to find out the laboratory they use and please bring your insurance card with you on the day of surgery.

FAILURE TO FOLLOW THE ABOVE INSTRUCTIONS WILL RESULT IN THE CANCELLATION OF YOUR SURGERY.

SIGNATURE OF PATIENT/ LEGAL GUARDIAN

DATE / TIME

PLEASE CHECK ONE OF THE FOLLOWING:

YES	NO1. Any problems with prior anesthetics? If yes, please describe:	
	 2. Have you ever had fever after an anesthetic? 3. Has any family member had problems with anesthetics, including malignant hyperthermia, paralysis, etc. 4. Do you smoke? 5. Do you drink alcohol? 6. Do you use any recreation drugs, including heroin, cocaine, marijuana, etc? 	?
	 7. Are you allergic to latex? 8. Have you taken steroids over the past year? 9. Can you climb 2 flights of stairs nonstop without getting chest pain or shortness of breath? 	
 	 10. Do you exercise? Type/how often?	
 	 What is the date of your last menstrual period? 13. Do you have any bleeding or clotting abnormalities including easy bruising or excessive vaginal bleeding 14. Do you have any implants? If yes, what type? 15. Have you had any recent colds? If yes, when? 	<u>3</u> ?
	 16. Do you have loose teeth, chipped teeth, dentures, caps, crowns, bridgework, braces? If yes, please list. 17. Do you have difficulty or pain with opening your mouth widely or tilting your head back to look above? 	
	18. Do you wear contact lenses or glasses?	
	DU HAVE ANY OF THE FOLLOWING? 1. Thyroid or goiter problems? 2. Diabetes or epilepsy? 3. Muscle weakness, paralysis, stroke? 4. High blood pressure? 5. Chest pain, angina? 6. Heart disease, murmur, mitral valve prolapse? 7. Lung disease, shortness of breath, chronic cough? 8. Asthma, wheezing? Last attack: 9. Kidney or bladder disease? 10. Hepatitis, jaundice, cirrhosis, HIV positive? 11. Ulcers? 12. Hiatal hernia or reflux? 13. Anemia or recent weight loss? 14. Have you ever had nose or jaw surgery? 15. Have you had any broken facial bones? 16. Frequent headaches or dizzy spells? 17. Any back problems, including surgeries, fractures, painful positions. 18. Motion sickness? 19. Have you ever taken Redux, Phen-Phen, or any other diet pill? Date	

Patient/Responsible Party Signature

Date _____



Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I,______, understand that as part of my health care, **North Atlanta ENT Surgical Center, LLC** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand and have been provided with a *Notice of Privacy Policies* that provides a complete description of information uses and disclosures in addition to my rights. I understand that **North Atlanta ENT Surgical Center, LLC** is not required to agree to any restrictions requested by me. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that **North Atlanta ENT Surgical Center, LLC** reserves any right to change their notice in accordance with Section 164.520 of the Code of Federal Regulations. Should **North Atlanta ENT Surgical Center, LLC** change their notice an updated copy will be available upon my next visit to the practice and/or I may request a copy be sent to my address. I also may visit the office at any time to obtain a current copy of the practice's *Notice*.

I wish to have the following restrictions to the use or disclosure of my health information:

I wish to allow the following individuals access to my medical records, medical information, billing and payment information with North Atlanta ENT Surgical Center, LLC:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Please initial by each form of communication by which we can contact the patient.

_____North Atlanta ENT Surgical Center, LLC may **call** my home at the following number and leave the appointment date and time on my telephone answering machine, voicemail, or with whomever answers my phone if I am not available. I understand that other individuals may have access to the information left by this method. I understand that no other information will be provided in granting permission to leave the date and time.

Telephone Number on which messages can beleft: ______

_____North Atlanta ENT Surgical Center, LLC may **email** my home or other email address any information that will assist ENT Surgical Center, LLC with the treatment, payment, and health care operations for the patient. This can include appointment reminders, statements, insurance information, and any information concerning my clinical care. **Email address to which information can be sent:**

_____North Atlanta ENT Surgical Center, LLC may send a **text message** to my cellular phone regarding appointment reminders, cancellations, or time changes. This form of communication will be for the use of the Appointment Desk and not private or clinical information.

Cell Phone to which information may be texted: ______

*** I fully understand and (circle one) [accept / decline] the terms of this consent. ***

Patient/Legal Guardian Signature	Date	Practice Representative	Date		
FOR OFFICE USE ONLY					
[] Consent received by		on			
[] Consent refused by patient, and treatment refused as permitted.					
] Notice provided to patient. Consent form not signed due to: Action to be taken:					



Statement of Nondiscrimination

North Atlanta ENT Surgical Center complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. North Atlanta ENT Surgical Center, does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. North Atlanta ENT Surgical Center provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats and more)

If you need these services for your surgical procedure, please tell the nurse during your preoperative interview or call **470-297-0257**.

If you believe that the North Atlanta ENT Surgical Center, has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Robyn Davis 4150 Deputy Bill Cantrell Memorial Rd. Suite #160 Cumming, Ga 30040 Phone: 470-297-0257 Fax: 770-292-3046

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, a patient representative will help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights complaint portal, available at <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>, or by mail or phone at:

Centralized Case Management Operations U.S. Department of Health and Human Services 200 Independence Ave. SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019 1-800-537-7697 (TDD)** Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Statements of Nondiscrimination in Languages Used in Georgia

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 470-297-0257

Spanish

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de interpretación. Comuníquese con alguien del personal de registros o llame al 470-297-0257.

Vietnamese

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin liên lạc với nhân viên phụ trách ghi danh hay gọi số 470-297-0257

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 706-364-4040 번으로 전화해 주십시오

Chinese 注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 470-297-0257

Gujarati

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470-297-0257

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 470-297-0257

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Amharic

297-0257

Hindi

धयान यदद आप हंद बोलते तो आपकोललए म**ुफ्त म भाषा स**ं यत**ा सेवाए**ं उपलब्ध । 470-297-0257 पर फोन दः करा

French Creole ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 470-297-0257

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 470-297-0257

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 470-297-0257

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 470-297-0257

Farsi

هجوت: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

470-297-0257

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich an das Anmeldungspersonal oder wählen Sie die Rufnummer 470-297-0257

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Japanese

注意事項:日本語での言語サポートを無料で提供しています。レジストレーション・スタッフ、または 470-297-0257までお問い合わせください。