



Patient Instructions Before Laser Procedure

At EPIC Surgery Centers, safety matters. We will be asking you the same questions several times to confirm that the information provided for your procedure is correct and up to date.

- **EATING & DRINKING:**
 - There are no eating or drinking restrictions for your laser procedure.
- **PREOP CALL:**
 - A nurse will call you several days prior to your surgery to review your health information & day of procedure instructions including your arrival time.
- **MEDICATIONS:**
 - Take your normal medications.
 - Bring your inhalers with you to the surgery center.
- **INSURANCE/PHOTO ID/CO-PAY:**
 - Your co-pay, insurance card(s) & Photo ID must be presented to the surgery center at check in. We accept Cash, Checks (no starter checks), Mastercard, Visa, Discover & American Express.
- **VALUABLES:**
 - Please leave valuables at home.
 - Dentures & hearing aids should not need to be removed for your procedure.
- Please do NOT wear scented lotion, perfume or cologne to the surgery center.

We at EPIC Surgery Centers want you to have your best surgical experience with us.

We are here to help you. For questions, please do not hesitate to call us at

913-261-2020



Receipt of Surgery Packet

Dear EPIC surgery patient,

Hello and welcome!. Enclosed is some information that you may want to know about. It is given to all surgery patients to help keep you informed. The forms are the same if you are having a small quick surgery or a very long complicated surgery.

Please review the packet, fill out the questions asked and bring this entire packet with you the day of surgery. A nurse will call you several days before the surgery to go over medicine that you take and your health history. On the day of surgery you will need to bring a driver's license or other photo identification.

Packet includes:

Pre-op Instructions – Please read ***

Health History Questionnaire – Please complete ***

Medication List – Please complete ***

Directions to the EPIC Surgery Center

Patient Bill of Rights – including information on how to report a concern or grievance at EPIC Surgery Center

Advance Directive Instructions

Disclosure of Ownership Statement

I have received the following documents prior to my surgery at EPIC Surgery Center:

Signature of Patient
(Or Guardian)

Date

Time



Health History Questionnaire

Name: _____ Age: _____ Wt: _____ Ht: _____

Do you wear? (Circle one)

Contacts: Y N Dentures: Y N Hearing Aids: Y N Left/Right/Both

Previous Surgeries:

The outcome I desire from having this surgery is:

Medical History (Check all that apply to you)

Cardiac <input type="checkbox"/> Angina/Chest Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Irregular Heart Beats <input type="checkbox"/> Coronary bypass # _____ <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Stent Placement	Lungs <input type="checkbox"/> Asthma/Use Inhalers <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD/Use Oxygen at home? <input type="checkbox"/> Bronchitis <input type="checkbox"/> Allergies/ Hay Fever <input type="checkbox"/> Sleep Apnea/Wear CPAP? <input type="checkbox"/> Smoker, ____# Packs per day	Thyroid <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hypothyroid
Kidney <input type="checkbox"/> Chronic Urinary Tract Infection <input type="checkbox"/> Dialysis, When _____ <input type="checkbox"/> Voiding at Night # _____	Liver <input type="checkbox"/> Hepatitis A, B, or C <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Chronic Pain Where: _____	Eyes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other <input type="checkbox"/> Retina Surgery <input type="checkbox"/> Cataract Surgery
Central Nervous System <input type="checkbox"/> Stroke/TIA's <input type="checkbox"/> Seizures/Migraines <input type="checkbox"/> Possibility that you might be pregnant? If yes, please speak with your surgeon	Other <input type="checkbox"/> Alcohol Use - How often _____ <input type="checkbox"/> Drug Use – Specify _____ <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> History of Mental Illness <input type="checkbox"/> Take/Have taken FLOMAX	Diabetics <input type="checkbox"/> Diet Controlled <input type="checkbox"/> Oral Meds <input type="checkbox"/> Insulin: Reg/NPH
Patient Sticker		

Patient/Guardian Signature: _____ Date: _____

There have been no changes to the above (to be signed at the surgery center if completed > 24 hours prior to surgery):

_____ Date: _____

Patient/Guardian Signature

MEDICATION LIST

ALLERGIES (Tape Iodine Latex Eggs Dyes Food Medication Anesthesia Other)			
ITEM	Type of Reaction	ITEM	Type of Reaction

Note: All home medications to be continued upon discharge unless a physician's order to change or discontinue a medication is written.

CURRENT MEDICATIONS

NONE ☐

List all prescriptions, over the counter medications, vitamins, aspirin, diet aids, herbs, laxatives, inhalers, eye drops, ointments.

CURRENT MEDICATION (Example: Tylenol)	DOSE (500mg)	ROUTE (By mouth)	FREQUENCY (Twice Daily)
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other

Patient or Guardian Signature: _____ Date _____ Time _____

There have been no changes to the above (to be signed at the surgery center if completed > 24 hours prior to surgery): _____ Date: _____

Patient/Guardian Signature



CURRENT MEDICATIONS (cont)

List all prescriptions, over the counter medications, vitamins, aspirin, diet aids, herbs, laxatives, inhalers, eye drops, ointments.

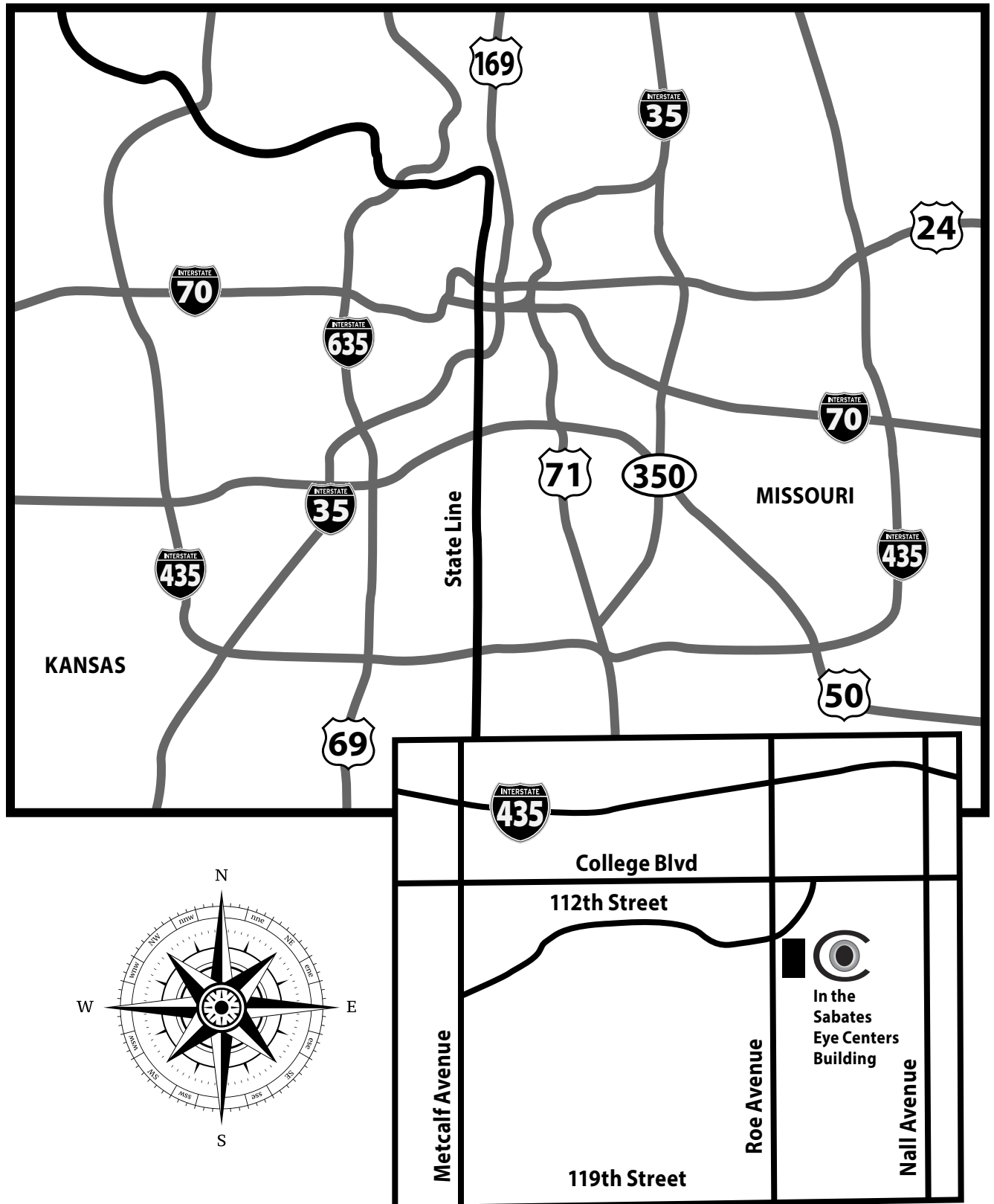
CURRENT MEDICATION (Example: Tylenol)	DOSE (500mg)	ROUTE (By mouth)	FREQUENCY (Twice Daily)
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
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		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other
		<input type="checkbox"/> By Mouth <input type="checkbox"/> _____	<input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> As Needed <input type="checkbox"/> Other

Patient or Guardian Signature: _____ Date _____ Time _____

There have been no changes to the above (to be signed at the surgery center if completed > 24 hours prior to surgery): _____ Date: _____

Patient/Guardian Signature





AS A PATIENT, YOU HAVE THE RIGHT TO:



- Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy and security for self and property.
- Have a surrogate (parent, legal guardian, person with medical power of attorney) exercise the Patient Rights when you are unable to do so, without coercion, discrimination or retaliation.
- Confidentiality of records and disclosures and the right to access information contained in your clinical record. Except when required by law, you have the right to approve or refuse the release of records.
- Information concerning your diagnosis, treatment and prognosis, to the degree known.
- Participate in decisions involving your healthcare and be fully informed of and to consent or refuse to participate in any unusual, experimental or research project without compromising your access to services.
- Make decisions about medical care, including the right to accept or refuse medical or surgical treatment after being adequately informed of the benefits, risks and alternatives, without coercion, discrimination or retaliation.
- Competent, caring healthcare providers who act as your advocates and treats your pain as effectively as possible.
- Know the identity and professional status of individuals providing service and be provided with adequate education regarding self-care at home, written in language you can understand.
- Be free from unnecessary use of physical or chemical restraint and or seclusion as a means of coercion, convenience or retaliation.
- Know the reason(s) for your transfer either inside or outside the facility.
- Impartial access to treatment regardless of race, age, sex, ethnicity, religion, sexual orientation, or disability.
- Receive an itemized bill for all services within a reasonable period of time and be informed of the source of reimbursement and any limitations or constraints placed upon your care.
- File a grievance with the facility by contacting the **Surgical Director**, via telephone or in writing, when you feel your rights have been violated.

Anna Lang, Director

11261 Nall, Suite 200
Leawood, KS 66211
(913) 671.3292

- Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments.
- Know about any business relationships among the facility, healthcare providers, and others that might influence your care or treatment.

- File a complaint of suspected violations of health department regulations and/or patient rights.
Complaints may be filed at:

Kansas Health Department of Aging
Complaint Department
503 S. Kansas Avenue
Topeka, KS 66603-3404
800.842.0078

Office of the Medicare Beneficiary Ombudsman
<http://www.cms.hhs.gov/center/ombudsman.asp>

AS A PATIENT, YOU ARE RESPONSIBLE FOR:

- Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate physician(s).
- Following the treatment plan recommended by the primary physician involved in your case.
- Providing an adult to transport you home after surgery and an adult to be responsible for you at home for the first 24 hours after surgery.
- Indicating whether you clearly understand a contemplated course of action, and what is expected of you, and ask questions when you need further information.
- Your actions if you refuse treatment, leave the facility against the advice of the physician, and/or do not follow the physician's instructions relating to your care.
- Ensuring that the financial obligations of your healthcare are fulfilled as expediently as possible.
- Providing information about, and/or copies of any living will, power of attorney or other directive that you desire us to know about.



Understanding Advance Healthcare Directives

Good advance planning for health care decisions is, in reality, a continuing conversation about values, priorities, the meaning of one's life, and quality of life.

With the increasing ability of medical science to sustain our lives, people are living much longer than ever before. Unfortunately, as we grow older and experience poor health, we may find ourselves in a position where decisions need to be made as to how we wish to be treated in a variety of medical situations at the end of our lives. Further, sometimes we find ourselves in a condition where we can no longer express our preferences.

Advance health care directives allow us to deal with these situations. Without such directives, your family may find it necessary to obtain court orders to deal with your medical situation. By expressing such preferences in a **written legal document**, you are ensuring that your preferences are made known. Physicians prefer these documents because they provide a written expression from you as to your medical care and designate for the physician the person he or she should consult concerning unanswered medical questions. Rather than the physician having to obtain a consensus answer from your family as to your treatment, the physician knows your preferences and knows who you want to provide decisions when you cannot do so. Making your wishes known in advance prevents family members from making such choices at what is likely one of the most stressful times in their lives.

It is the policy of EPIC Surgery Centers, regardless of any advance directives or instructions from a health care surrogate or power of attorney, that an unexpected medical emergency, which occurs during treatment at this facility, will be aggressively managed with resuscitative or other stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney.

Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Resources to help you to create an Advance Directive:

□ This webpage, hosted by the U.S. Living Will Registry, provides a state-by-state list, with links to state specific websites that provide free advance directive forms.

<http://www.uslivingwillregistry.com/forms.shtm>

□ This webpage provided by the American Bar Association provides a great tool kit which contains a variety of self-help worksheets, suggestions, and resources. There are 10 tools in all, each clearly labeled and user-friendly. The tool kit does not create a formal advance directive for you. Instead, it helps you do the much harder job of discovering, clarifying, and communicating what is important to you in the face of serious illness.

<http://www.abanet.org/aging/toolkit/home.html>



Disclosure of Ownership

Let it be known that the following physicians are owners of the limited liability corporation know as EPIC Surgery Centers, LLC.

Rohit Krishna M. D.

Nelson R. Sabates M.D.

David B. Lyon M. D.

Abraham K. Poulouse M.D.

Michael A. Cassell M.D.