PINNACLE
SURGERY CENTER

Important Information

1. Documents - please fill out the following and bring them with you on the day of your procedure.
   a. Medication Reconciliation Form
   b. Patient Notification and Acknowledgement
   c. Driver's Information and Emergency Contact

2. Identification - please bring your photo ID and insurance card(s). We must have a copy of each on file.

3. Financial Responsibility - you may be responsible for 3 separate payments.
   a. Surgery center – we will call you a few days prior to your procedure only if you have an amount due.
   b. Physician's office – this is paid directly to their office and is separate from the surgery center.
   c. Anesthesia (USAP) – they will send a statement a few weeks after your procedure. Please call (702) 878-0070 with any questions regarding their services.

4. Preop Call - one of our pre-op nurses will call you one to two days prior to your procedure with your arrival time and pre-op instructions. If you miss that call, please check your voicemail. They leave detailed instructions there.

If you have any questions, please contact us at (719) 418-4700.

2770 N. Union Blvd., Ste 180, Colorado Springs, CO 80909
719-418-4700 (main) / 719-418-4750 (fax)

PINNACLE
SURGERY CENTER

(Patient Sticker)

MEDICATION RECONCILIATION FORM

(This is not a physician order form)

Allergic To	Reaction	Allergic To	Reaction

Medication/Dose	Last Taken			Resume at DC			Additional Comments
	DATE	DATE	DATE				
Vitamins ☐ Yes ☐ No				Y/N	Y/N	Y/N	
Fish Oil ☐ Yes ☐ No				Y/N	Y/N	Y/N	
Aspirin__mg ☐ Yes ☐ No				Y/N	Y/N	Y/N	

☐ Patient is not taking any medication(s) prior to admission, including OTC medications, vitamins herbal supplements, etc.

CURRENT PRESCRIPTION MEDICATION (Continued on page 2)

Resume at DC			Medication Name	Dosage	Frequency	Last Taken			If Held, Resume On
DATE	DATE	DATE				DATE	DATE	DATE	
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							

My post-operative medication reconciliation form has been explained to me.
I understand the instructions and a copy has been given to me.

SIGNATURE PATIENT / RESPONSIBLE PARTY / DATE	RN SIGNATURE	PHYSICIAN SIGNATURE
SIGNATURE PATIENT / RESPONSIBLE PARTY / DATE	RN SIGNATURE	PHYSICIAN SIGNATURE
SIGNATURE PATIENT / RESPONSIBLE PARTY / DATE	RN SIGNATURE	PHYSICIAN SIGNATURE

CURRENT PRESCRIPTION MEDICATION (Continued from page 1)

Resume at DC			Medication Name	Dosage	Frequency	Last Taken			Additonal Commen
DATE	DATE	DATE				DATE	DATE	DATE	
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							
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Y/N	Y/N	Y/N							
Y/N	Y/N	Y/N							

OFFICE USE ONLY

PRESCRIPTIONS WRITTEN BY SURGEON DAY OF SURGERY

☐ None ☐ Given in Office ☐ DOS Indicat

PATIENT NOTIFICATION AND ACKNOWLEDGMENT

Notice of Rights and Responsibilities

Pinnacle Surgery Center has established a Patient's Bill of Rights and Responsibilities, which is provided verbally and in writing in a language and manner the patient, patient's representative or surrogate understands prior to their procedure. Pinnacle Surgery Center expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the Center.

Notice of Privacy Practices PHI and HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessment and physician certification.

A complete copy of Pinnacle Surgery Center's notice of privacy practice is posted in the Center. I have been informed by this Center of their written Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy. I understand that I may request in writing that the Center restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that I may revise this consent in writing at any time, except to the extent that the Center has already taken action relying on this consent. **I Give Permission** for my protected health information (PHI) to be disclosed for purposes of communicating results, findings and care decisions to the family members and others.

☐ **Yes** ☐ **No** ☐ **Limited disclosure to persons listed below:**

Name: _____ **Date:** _____

Name: _____ **Date:** _____

Financial Disclosure/Ownership in the Center

Pinnacle Surgery Center is privately owned and has informed the patient prior to the procedure that their physician may have a proprietary interest in this facility. I have the right to choose the facility of my choice for health related services. I have been given this option and choose to have my procedure at Pinnacle Surgery Center.

Advance Directive

It is the policy of Pinnacle Surgery Center, regardless of any advance directive 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 measure followed by emergency transfer to the closest hospital. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care directive or health care power of attorney.

Please check the appropriate box

☐ **Yes,** I have an advance health care directive, living will and/or a power of attorney.
☐ I have provided a copy of my advance health care directive, living will and/or power of attorney to the Center.
☐ **No,** I do not have an advance health care directive, living will and/or a power of attorney.
☐ **Yes,** I would like additional information on advance health care directives including information on my states law regarding advance health care directives.

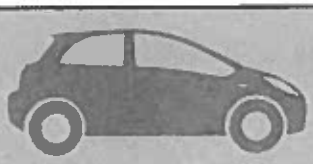
Grievances Procedure

All alleged grievances will be fully documented, investigated and reported to the Clinical Director of Pinnacle Surgery Center. Any substantiated allegation will be reported to the State of Colorado and/or Local authority. The grievance documentation will be included in the process of how the grievance was addressed and the patient will be provided a written notice of the decision within fifteen (15) days of receipt of the grievance.

By signing this document, I acknowledge that the above information was given to me prior to my procedure, and that I have read and understand the information. I agree to the policies of Pinnacle Surgery Center. If I have indicated I would like additional information, I acknowledge receipt of that information.

_____ _____

Patient Signature (if patient is unable to sign, please indicate realtionship) / Witness Signature — Date



Driver's Information

Driver's Name:	
Relation:	Driver's Cell #:
Make/Model of Driver's Car:	Color of Driver's Car:

YES ☐ NO ☐ Is the driver staying in the waiting room?

PLEASE NOTE:

If your driver will not be staying in the waiting room, please ensure they have their cell phone on and are able to arrive within 10 minutes of being contacted. Although the total surgery process typically takes 2 to 2.5 hours from check-in, you may be ready to leave sooner. If needed, there are restaurants and parks nearby where they can wait.

In case of Emergency

(If different from above)

Name:	
Relation:	Phone: