Name_____

EVANGELICAL AMBULATORY SURGICAL CENTER
Is an affiliate of Evangelical Community Hospital

Date of Surgery_____

WELCOME

The staff of the Evangelical Ambulatory Surgical Center is pleased that you have made the decision to utilize our surgery center. We want to make your upcoming procedure as comfortable and as pleasant as possible. We realize that even "outpatient" surgery, such as the procedure for which you are scheduled, can create anxiety. This information has been created to answer many of the questions you may have related to your upcoming procedure. **Please review all the topics covered in this packet and bring this page with you on the day of your pre-admission testing (if you have an appointment scheduled here) or on the day of your procedure.**

Pre-operative Instructions for Surgery:

- Guidelines
- Medications
- Minor Children
- After Surgery
- Licensed Driver
- Financial Arrangements
- Patient Bill of Rights (Written)
- Patient Bill of Rights (Verbal)
- Patient Responsibilities
- Patient Complaints and Grievance Policy
- Advance Directive Policy

Acknowledgement: I, the undersigned, verify that I have read and fully understand the information contained in this Evangelical Ambulatory Surgical Center Packet. I understand the **pre-operative instructions;** and, if I have any questions, I may call the Pre-Admission Department at **570-768-3331** or **570-768-3300.**

Patient or Guardian Signature: _____ **Date:** _____

IT IS VERY IMPORTANT THAT YOU COMPLETE THIS PACKET

AFFIX PATIENT LABEL

EVANGELICAL™
AMBULATORY SURGICAL CENTER
210 JPM Road, Lewisburg, PA 17837
Phone: 570-768-3300 – Fax: 570-768-3970

Medication Reconciliation Record

Date	Medications	Dosage	How many times/day?	Last Dose
	Herbal/Vitamins/Over the Counter			

Information Obtained from:

- ☐ **Patient/Family**
- ☐ **Retail Pharmacy**
- ☐ **Bottles/List**
- ☐ **Old Records**
- ☐ **PCP Records**
- ☐ **Surgeon's Office**
- ☐ **Other_____**

_____

☐ **I DO NOT TAKE ANY MEDICATION**

ALLERGIES/REACTIONS:

☐ **LATEX** **FOOD ALLERGIES/REACTIONS:**

E.A.S.C. STAFF WILL COMPLETE BEYOND THIS POINT

MEDICATIONS ADDED THIS VISIT: _____

☐ **NO MEDICATIONS ADDED THIS VISIT**

☐ **INSULIN DEPENDENT PATIENTS may resume insulin. (*If not eating well, call your family doctor for instructions*.)**

☐ **Resume all medications, except:_____**

If you have any questions about the medications on this list, call your family doctor

Signature of Nurse Verifying List: _____

Medication Reconciliation performed by: _____

Patient Signature: _____ Page _____ of _____

Patient's Name: _____

DOB:_____

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ADULT MEDICAL HISTORY FORM

1. PRESENT ILLNESS AND DURATION:

2. SCHEDULED SURGERY:

3. DATE OF SURGERY:

4. If you are now under regular medical care, list reason and duration:

Primary Care Physician:_____

Office Location: _____

5. Height _____ **Weight** _____ **BMI** _____

6. FEMALE PATIENTS:

Date of last menstrual period: _____

Are you now pregnant? ☐ no ☐ yes

Should we test you for pregnancy? ☐ no ☐ yes

# of previous pregnancies: _____

# of living children: _____

# of miscarriages: _____

Identify any pregnancy complications:

7. MALE PATIENTS:

Prostate disorder ☐ no ☐ yes

Erectile problems ☐ no ☐ yes

HAVE YOU EVER HAD OR NOW HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? PLEASE CHECK YES OR NO FOR EACH CONDITION.

(Check "current" if you are currently under any form of treatment for the condidtion)

8. LUNG DISEASE		Past	Current
Do you use oxygen?	☐ no	☐ yes	☐
Asthma	☐ no	☐ yes	☐
Emphysema	☐ no	☐ yes	☐
Pneumonia	☐ no	☐ yes	☐
Bronchitis	☐ no	☐ yes	☐
Tuberculosis	☐ no	☐ yes	☐
Daily cough	☐ no	☐ yes	☐
Dry cough	☐ no	☐ yes	☐
Productive cough/cough up blood	☐ no	☐ yes	☐
Shortness of breath	☐ no	☐ yes	☐
Wheezing	☐ no	☐ yes	☐
Are you able to walk up 2 flights of stairs without shortness of breath?	☐ no	☐ yes	☐

9. TOBACCO HISTORY

Have you ever smoked regularly?

☐ yes ☐ no ☐ now

☐ pipe ☐ cigar ☐ chew ☐ cigarettes

quantity: _____packs/day and duration: _____years

If you've quit, when did you last smoke? _____

Date & Location of last chest-x-ray: (if known) _____

_____

10. CARDIOVASCULAR DISEASE		Past	Current
High blood pressure	☐ no	☐ yes	☐
Abnormal pulse/rhythm/Pacemaker	☐ no	☐ yes	☐
Murmur/Palpitations	☐ no	☐ yes	☐
Ankle swelling/edema	☐ no	☐ yes	☐
Peripheral Vascular Disease/Circulation problems	☐ no	☐ yes	☐
Elevated cholesterol	☐ no	☐ yes	☐
Chest pain/tightness	☐ no	☐ yes	☐
Angina/chest heaviness/heart attack	☐ no	☐ yes	☐
Stent or Cardiac Surgery (date:_____)	☐ no	☐ yes	☐
History Rheumatic Fever	☐ no	☐ yes	☐
Congestive Heart Failure	☐ no	☐ yes	☐
Calf pain when walking	☐ no	☐ yes	☐
How far can you walk until legs are painful _____	☐ no	☐ yes	☐
Pain in feet at night	☐ no	☐ yes	☐
Does it wake you up	☐ no	☐ yes	☐
Relieved by standing or hanging leg down	☐ no	☐ yes	☐
Leg or Foot ulcers	☐ no	☐ yes	☐
Echocardiogram (date/place:_____)	☐ no	☐ yes	☐
Stress Test (date/place: _____)	☐ no	☐ yes	☐
Do you have cardiac studies scheduled?	☐ no	☐ yes	☐

11. BLOOD DISORDERS			
Anemia/Low blood count	☐ no	☐ yes	☐
Bleeding tendencies/clotting disorder/ Deep Vein Thrombosis	☐ no	☐ yes	☐
Prior transfusion	☐ no	☐ yes	☐
Transfusion reaction	☐ no	☐ yes	☐
Family history of bleeding/clotting disorder/ Deep Vein Thrombosis	☐ no	☐ yes	☐

12. INFECTIOUS DISEASE			
Hepatitis A B C	☐ no	☐ yes	☐
MRSA/ Other:_____	☐ no	☐ yes	☐
HIV/AIDS	☐ no	☐ yes	☐

13. TUMORS (specify type and location)

Benign _____

Cancer/malignant _____

14. DIGESTIVE DISORDER			
Nausea/vomiting	☐ no	☐ yes	☐
Abdominal pain	☐ no	☐ yes	☐
Ulcer/bleeding	☐ no	☐ yes	☐
Change in stool habits/bloody stools/ black tarry stools	☐ no	☐ yes	☐
Yellow jaundice/Liver Disease	☐ no	☐ yes	☐
Hiatal Hernia/Reflux/Indigestion/Heartburn	☐ no	☐ yes	☐

15. KIDNEY/BLADDER DISEASE			
Bladder/Kidney infection	☐ no	☐ yes	☐
Frequent urination/Pain on urination	☐ no	☐ yes	☐
Stones	☐ no	☐ yes	☐
Blood in urine	☐ no	☐ yes	☐
Kidney failure/dialysis	☐ no	☐ yes	☐

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ADULT MEDICAL HISTORY FORM

16. METABOLIC/ENDOCRINE (Past / Current)
- Diabetes ☐ no ☐ yes ☐
- Thyroid disorder ☐ no ☐ yes ☐
- Adrenal ☐ no ☐ yes ☐
- Prolonged Prednisone/Steroid use ☐ no ☐ yes ☐

17. EYE, EAR, NOSE, & THROAT
- Vision problems ☐ no ☐ yes ☐
- Hoarseness ☐ no ☐ yes ☐
- Hearing problems ☐ no ☐ yes ☐
- Difficulty swallowing ☐ no ☐ yes ☐
- Glaucoma ☐ no ☐ yes ☐
- Sinusitis ☐ no ☐ yes ☐
- Dentures/Caps/Appliances ☐ no ☐ yes ☐
- History of motion sickness ☐ no ☐ yes ☐

18. NEURO/MUSCULAR DISEASE
- Seizures/Convulsions ☐ no ☐ yes ☐
- Unconsciousness ☐ no ☐ yes ☐
- Stroke/Paralysis/TIA ☐ no ☐ yes ☐
- Abnormal muscular weakness ☐ no ☐ yes ☐
- Peripheral Neuropathy ☐ no ☐ yes ☐
- Frequent Headaches ☐ no ☐ yes ☐
- Strabismus/Tremors/Tics ☐ no ☐ yes ☐

19. PSYCHOLOGICAL
- Depression ☐ no ☐ yes ☐
- Emotional illness ☐ no ☐ yes ☐
- Anxiety ☐ no ☐ yes ☐
- "Nerves" ☐ no ☐ yes ☐

20. BONE/JOINT DISEASE
- TMJ ☐ no ☐ yes ☐
- Back problems ☐ no ☐ yes ☐
- Arthritis ☐ no ☐ yes ☐
- Joint pain/swelling/warmth ☐ no ☐ yes ☐
- Recent fractured bones ☐ no ☐ yes ☐
  specify:
- Scoliosis ☐ no ☐ yes ☐
- Disc Disease ☐ no ☐ yes ☐
- Decreased Neck Mobility ☐ no ☐ yes ☐

21. OTHER MEDICAL CONDITIONS: ☐ None

22. PAST HOSPITALIZATIONS: ☐ None

List year and reason (list most recent first):

1)
2)
3)
4)
5)

23. PREVIOUS OPERATIONS: ☐ None

List year, reason, & name of hospital (list most recent first):

1)
2)
3)
4)

24. Unusual or Complicated Anesthesia ☐ no ☐ yes
- Malignant Hyperthermia ☐ no ☐ yes
  explain:
- Do you have sleep apnea? ☐ no ☐ yes
  - If yes, do you use oxygen at night? ☐ no ☐ yes
  - Do you use a CPAP machine? ☐ no ☐ yes
- History of loud snoring? ☐ no ☐ yes
- History of daytime sleepiness? ☐ no ☐ yes

25. LIST ALL MEDICATIONS YOU ARE NOW TAKING:
(Please include non-prescriptions & herbs)
☐None

26. ALLERGIES: (List reaction)
☐None ☐ IV Contrast ☐Latex ☐ Shell Fish
Please list, including reaction: _____
_____
_____
_____

27. FAMILY HISTORY: (List relationship to you)
- Heart Disease
- Stroke
- Asthma
- Diabetes
- High Blood Pressure
- Cancer (specify):

28. SOCIAL HISTORY
- Do you live alone? ☐ no ☐ yes
- Do you feel safe at home? ☐ no ☐ yes
- Do you consume alcohol regularly? ☐ no ☐ yes
  If yes, how much daily? _____
- Have you ever abused any drugs? ☐ no ☐ yes
  please specify: _____
- Hazardous substance exposure on the job? ☐ no ☐ yes

_____ _____
Signature Date

Evangelical Ambulatory Surgical Center
210 JPM Road, Lewisburg, PA 17837
Phone 570-768-3300 --- Fax 570-768-3970

PEDIATRIC MEDICAL HISTORY FORM

Dear Parent/Guardian: Your answers to these questions will contrubute to the betterment of your child's hospital experience by providing medical knowledge about your child. This will reduce risks and increase the safety and comfort of your child.

1. BIRTHDATE: _____

Premature Delivery ☐ yes ☐ no
If yes, how much: _____
Normal Delivery ☐ yes ☐ no
Birth Weight: _____
Birth Defects ☐ yes ☐ no

2. ILLNESS TO DATE: (include year)

3. UNDER DOCTOR'S CARE NOW
Reason and Duration:

4. PREVIOUS OPERATIONS/INJURIES ☐ yes ☐ no
Please list:

5. PREVIOUS ANESTHESIA DIFFICULTIES ☐ yes ☐ no

6. HEART DISEASE

Capable of Normal Activities ☐ yes ☐ no
Blueness with exercise ☐ yes ☐ no
Known heart murmur ☐ yes ☐ no
Known heart defects ☐ yes ☐ no
Other:

7. LUNGS/BREATHING PROBLEMS

Respiratory problem at birth ☐ yes ☐ no
Frequent bronchitis ☐ yes ☐ no
Asthma ☐ yes ☐ no
Other:

8. NERVE/MUSCLE DISEASE

Abnormal Muscle Weakness ☐ yes ☐ no
Known Disease of Nerves ☐ yes ☐ no
Emotional Disturbances ☐ yes ☐ no
Convulsions ☐ yes ☐ no
Fainting/Unconscious Spells ☐ yes ☐ no

9. BLOOD DISORDERS

Anemia ☐ yes ☐ no
Blood transfusion in past ☐ yes ☐ no
Blood transfusion reaction ☐ yes ☐ no
Other:

10. ANY OF THESE CONDITIONS

Diabetes ☐ yes ☐ no
Jaundice ☐ yes ☐ no
Frequent bad bruises ☐ yes ☐ no
Abnormal bleeding ☐ yes ☐ no
Frequent high fever ☐ yes ☐ no
Any glandular disorder ☐ yes ☐ no
Bladder infections ☐ yes ☐ no

11. EYE, EAR, NOSE, & THROAT

Frequent colds/sniffles ☐ yes ☐ no
Frequent sore throat ☐ yes ☐ no
Any ear infections ☐ yes ☐ no
Any eye disease ☐ yes ☐ no
Deformity of mouth or teeth ☐ yes ☐ no

12. SKIN RASHES ☐ yes ☐ no
Type and Year:

13. STOMACH/INTESTINAL DISORDERS ☐ yes ☐ no

ACID REFLUX ☐ yes ☐ no

14. ANY CONGENITAL DISEASE ☐ yes ☐ no

15. ALLERGIES: (list in detail) ☐ yes ☐ no

16. LIST ALL DRUGS/MEDICATIONS NOW BEING TAKEN:

17. ANY OTHER MEDICAL PROBLEMS ☐ yes ☐ no
Please list:

My child may not have anything to eat or drink six hours prior to the operation time. If he/she does, I understand the operation may be cancelled or postponed.

_____ _____
Signature of Parent/Guardian Date

EASC

Evangelical Ambulatory Surgical Center

210 JPM Road • Lewisburg, PA 17837 www.evanasc.com Phone 570-768-3300 • Fax 570-768-3970

IMPORTANT

Pre-Admission Care:

You will be scheduled for a preadmission phone call. It is important that you keep this appointment. Failure to complete the preadmission phone call prior to your surgery will result in the delay of your surgery date.

If you need to change this appointment or you miss the appointment, please call 570-768-3331 or 570-768-3300 to reschedule at your earliest convenience.

Your medications and medical history will be reviewed. Please have this information available when calling to speak with the PAC nurse. Please allow approximately 30 minutes for this phone call appointment. The PAC nurse will also review post-operative instructions and answer questions about surgery at EASC.

We look forward to speaking with you.

Pre-operative Instructions for Surgery:

To help us meet all your needs, please follow these guidelines:

- Please **review** all directions provided to you by the Pre-Admission nurse OR your surgeon's office with regards to eating and drinking.
- **Bath or shower and brush your teeth** (taking care not to swallow any water) the morning of your surgery. This will assist you in feeling refreshed as well as minimize the chance of infection.
- **Remove all mascara, make-up and jewelry.** If you wear contact lenses or glasses, bring a case for their safe keeping. For your safety, **ALL** piercings must be removed before arrival to the surgery center. This includes **METAL and PLASTIC** earrings, tongue, brow, lip, etc... Piercings.
- **Wear loose fitting, comfortable clothing that** are large enough to accommodate a large bandage after surgery if needed. Wear comfortable shoes, no high heels, sandals or flip flops, please.
- **Leave all valuables, including jewelry and cash at home.** We cannot be responsible for damaged or lost property.
- **Please arrive at the time given to you.** This allows ample time to prepare you for your procedure. Your family/escort will be asked to wait in the waiting room. **No children under the age of 14 years of age will be allowed in the patient areas.** If you have small children, please bring additional adults to supervise them in the waiting room.
- **If you are the guardian or caregiver for a special needs person,** please call the center at 570-768-3300.
- **Crutches – If your surgery requires the use of crutches,** talk to your doctor about where to get them and crutch training. It is important that the crutches are properly measured and you know how to use them. Please bring them with you on the day of your procedure.

Medications:

- Please **review** all directions provided to you by the Pre-Admission nurse OR your surgeon's office with regards to medications you should take, medications you should not take.

Minor Children:

- **Patients under the age of 18** must have one parent or legal guardian in the surgery center until the patient is discharged.
- **Foster Parents should call** the surgical center with questions at 570-768-3300.
- **Do not send** a grandparent or step-grandparent with the patient unless they are the legal guardian. Power of Attorney forms must be presented for proof of guardianship.
- **Please feel free** to bring any stuffed animals or a security blanket for added reassurance.
- **Children may come in their pajamas;** you may need to bring extra clothing, especially underwear.
- **If your child cannot drink from a cup,** please bring a bottle or sippy cup.
- **It is best to have someone accompany the driver** in order to help care for the child on the trip home.
- **Only two people may be with a child** in the recovery room.

After Surgery:

The length of stay post-operatively varies according to the type of procedure and your physician's instructions. Most patients are discharged within one hour after surgery is completed.

- Please remember that you may require admission to the hospital in the event of medical need.
- **A responsible person shall be available to drive/escort you home** at time of discharge, they need to remain in the surgery center or be within a 15 minute return time upon being called.
- **Your physician and nurse** will provide post-operative instructions. Please follow all instructions carefully so your recovery will be as quick and comfortable as possible.

- **Pain medicine may be prescribed for your post-operative pain.** Always take as directed. If your doctor does not prescribe pain medicine, you may take an over the counter pain medicine such as Ibuprofen, Aleve or Tylenol.
- **If you have a question regarding your procedure after discharge,** contact your physician at the number on the discharge instructions sheet. **If you have an emergency, *seek medical attention from the local emergency room.***

Licensed Driver:

- **A responsible driver must be available to drive you home** after surgery because you may receive medication/anesthesia that will make you drowsy and slow your reaction time. Your driver is to remain at the surgery center. If they need to leave for any reason, they must be able to return within a 15 minute timeframe. Failure to have someone available to drive you home will result in cancelling or rescheduling your procedure. We recommend that someone remain with you for the first 24 hours after your procedure.

Financial Arrangements:

Evangelical Ambulatory Surgery Center (EASC) is committed to providing safe, high-quality patient care. EASC is owned entirely by Evangelical Community Hospital, and it is a department of the hospital, just like the operating rooms in the main facility. At EASC, we strive to assure every patient has the highest level of satisfaction. We understand your medical bills can be confusing or difficult to understand. Therefore, we are providing you the following information to help you understand the various components related to payment of your procedure.

Billing for Services

Evangelical Community Hospital will send a bill to your health insurance company on your behalf for services rendered at EASC. This bill will include charges related to use of our facility, such as:

- Pre-procedural services (i.e. laboratory studies, EKG's, x-rays, etc.)
- Use of the operating room or procedural room
- Routine equipment and supplies
- Medications used before, during and after your procedure
- Professional services by CRNA personnel providing care
- Recovery Room charges

Outpatient procedures are generally covered by your medical insurance. The charges become your responsibility if your medical insurance company does not pay them, so it is important to provide accurate insurance policy information at the time of your appointment.

Insurance Cards and Identification

To assist us in properly processing a claim for services, please bring your insurance cards with you on the day of surgery. We will also need a Photo ID such as your driver's license. We will make a copy of both for our records.

Medicaid patients must have a current, valid Medicaid card with them at the time of admission.

Worker's Compensation/Auto Claims

To aid us in billing for these claims, we ask that you bring your "claim number," date of injury, and carrier information with you on the day of surgery. We will also photocopy your health insurance cards. This is done in the event that your auto benefits exhaust or your worker's compensation claim denies.

Co-payments/co-insurance and Applicable Deductible Payments

You may be asked for a partial payment upon admission to EASC, dependent upon your insurance coverage. We make every effort to advise you of the amount prior to your admission. The fee given you is based upon the information we have at the time your insurance coverage is verified. There may be an additional amount due once the claim is submitted and processed by your medical insurance. Your insurance carrier makes the final determination of patient responsibility.

Payment in Full

Evangelical Community Hospital, through contracts or participation agreements, accepts insurance payments as "payments in full" from participating insurance companies, except for patient deductibles and co-payments/ co-insurance as noted above.

Cosmetic Surgery

Patients having cosmetic surgery procedures are required to pay the full amount on or before the day of surgery.

Paying your bills

- We accept cash, cashier's checks, and money orders.
- Mastercard, Discover, and Visa credit cards are accepted.
- If you are unable to pay your balance at one time, Evangelical Community Hospital will set up a payment plan for you. Please contact the Patient Accounting Department at 570-522-2552 for more details.

Questions

Please call one of our experienced Patient Account Representatives at 570-522-2552, if you have any questions or to:

- Get help understanding your bill
- Establish a payment plan for a bill
- Made a payment
- Update or change the insurance information we have on file for you

Patient Bill of Rights:

EVANGELICAL AMBULATORY SURGICAL CENTER is committed to providing comprehensive health care in a manner which acknowledges the uniqueness and dignity of each patient. We encourage patients and families to have clear knowledge of, and to participate in, matters and decisions related to their medical care.

1. A patient has the right to respectful care given by competent personnel.
2. A patient has the right, upon request, to be given the name of his attending practitioner, the names of all other practitioners directly participating in this care, and the names and functions of other healthcare persons having direct contact with the patient.
3. A patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly.
4. A patient has the right to have records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.
5. A patient has the right to know what facility rules and regulations apply to his conduct as a patient.
6. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
7. The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
8. The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the responsible person.

9. Except for emergencies, the practitioner shall obtain the necessary informed consent prior to the start of a procedure.
10. A patient (or, if the person is unable to give informed consent, a responsible person) has the right to be advised when a practitioner is considering the patient as part of a medical care research program or donor program. The patient or responsible person shall give informed consent prior to actual participation in the program. A patient or responsible person may refuse to continue in a program to which he has previously given informed consent.
11. A patient has the right to refuse drugs or procedures to the extent permitted by statute, and practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.
12. A patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, gender, sexual orientation, national origin, handicap, disability or source of payment.
13. The patient who does not speak English shall have access, where possible, to an interpreter.
14. The facility shall provide the patient or patient designee, upon request, access to the information contained in his medical records unless access is specifically restricted by the attending practitioner for medical reasons.
15. The patient has the right to expect good management techniques to be implemented within the facility. These techniques shall make effective use of the time of the patient and avoid the personal discomfort of the patient. When an emergency occurs and a patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.
16. The patient has the right to examine and receive a detailed explanation of his bill.
17. A patient has the right to expect that the facility will provide information for continuing health care requirements following discharge and the means of meeting them.
18. A patient or family member has the right to express their concern with or complain about any aspect of care and to expect a response to significant complaints. Expressing a complaint will not compromise the patient's treatment or future access to care.
19. A patient has the right to be informed of his rights both verbally and written prior to the date of the procedure.
20. A patient has the right to be free from abuse or harassment.

Verbal Patient's Bill of Rights:

The Evangelical Ambulatory Surgical Center Conditions of Coverage require that each patient or the patient's representative receives the Patient's Bill of rights verbally. Please call 570-524-6768 prior to the procedure, if you desire verbal communication of your rights.

Patient Responsibilities:

- **Be respectful** of all the health care providers and staff, as well as other patients.
- **Accept personal financial responsibility** for any changes not covered by his/her insurance. Make financial arrangements prior to PAT process.
- **Sign consent form.**
- **Report for pre-operative testing and procedure** as scheduled by surgeon; or if necessary to cancel it, give at least **24 hours notice**.
- **Inform his/her provider about a living will,** medical power of attorney or other directive that could affect care.
- **Provide complete and accurate information** to the best of your ability about your health, any medications, including over the counter products and dietary supplements and any allergies or sensitivities.
- **Follow all pre-operative instructions** as given by the physician and/or pre-operative nurse.
- **Follow discharge instructions** as given by the physician and/or PACU nurse.
- **Provide transportation** to and from the surgical center by a responsible person**.**
- **Follow surgical center policy on valuables.**

Patient complaints & Grievance Policy:

- **The staff of the EASC values you as a patient.** We are dedicated to ensuring your relationship with us is a positive one. If we can enhance that relationship in any way, please let us know.
- **Every patient has the right to express complaints** about the care and services provided, to any staff member.
- **If the patient is not satisfied with the resolution,** the complaint is taken to the Administrative Director.
- **Patients or the patient's representative** may file a written or verbal complaint/grievance with the Administrative Director at:

  Evangelical Ambulatory Surgical Center [An affiliate of Evangelical Community Hospital]
  Kimberly A Wheeland, MSN, BSN, RN, CMSRN
  210 JPM Road Suite 100
  Lewisburg, PA 17837

- **The patient or patient's representative** will be notified, by telephone, within three business days of the time the grievance is made that an internal investigation is being conducted.
- **The patient has the right, if he or she is not satisfied with the facility's response, to complain to the following agencies:**

  Website for the Office of the Medicare Beneficiary Ombudsman
  www.cms.hhs.gov/center/ombudsman.asp

- Please contact The Evangelical Ambulatory Surgical Center with complaints.
- If you are not satisfied with the outcome of your discussions after filing a complaint internally with the EASC, the following anonymous hotline numbers are available: For complaints against a healthcare facility, please contact the:

  Department of Health at 1-800-254-5164 or in writing at:

  PA Department of Health
  Division of Ambulatory Surgery- Room 532
  Health and Welfare Building
  625 Forster St.
  Harrisburg, PA 17120

- **For more information on the Pennsylvania Patient Safety Authority go to: www.patientsafetyauthority.org.**

Advance Directive Policy:

- **All the patient have the right to participate in their own health decisions** and to make Advance Directive or to execute Powers of Attorney that authorizes others to make decisions on their behalf based on patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. The EASC respects and upholds these rights.
- **However, unlike an acute care hospital setting,** the surgical center does not routinely perform "high risk" procedures.
- **Most procedures performed in this facility are considered to be of minimal risk**, though no surgery is without risk. You will discuss the specifics of your procedure with your physicians who can answer your questions as to the risks involved, your expected recovery and care after surgery.
- **Therefore, it is our policy, regardless of the contents of any advance directive or instructions for a health care surrogate or attorney** that is an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of

treatment measures already begun will be ordered in accordance with your wishes, Advance Directive or health care power of attorney.

- **Your agreement with the policy** does not revoke or invalidate any current health care directive or healthcare power of attorney.
- **If you do not agree with this policy,** we are pleased to assist you in rescheduling your procedure.