SOUTH PORTLAND SURGICAL CENTER
6370 SW Borland Road Suite 100
Tualatin, OR 97062
Phone: 503-218-1105

Welcome!

On behalf of the entire staff, we welcome you and look forward to your upcoming visit at South Portland Surgical Center. Our staff is dedicated to providing individualized, high quality medical care in a confidential, caring, and respectful environment.

We have enclosed the following documents for you to complete and bring with you to your appointment:

- South Portland Surgical Center Brochure
- Registration Form
- Financial/Billing Policy
- Pre-Anesthesia Questionnaire
- Deep Vein Thrombosis (DVT) Risk Assessment
- Patient Medication Reconciliation

Please help us better serve you and make your admission process as easy as possible by reading all of the enclosed forms and completing all enclosed forms before you arrive at our facility. Please remember to complete the Patient Medication Reconciliation form in its entirety, including dose, frequency, date/time last taken, route and the purpose for use.

Your doctor's office will contact you to confirm your appointment date and time. Please be mindful your appointment time can be subject to change for a variety of reasons. If you have not heard from your doctor's office 24 hours prior, please call their office to confirm there have been no changes.

You will receive a call from a nurse at our facility 24-48 hours prior to your appointment to review your medical history. We recommend having your registration forms completed prior to that call to expedite the process.

Financial Information: We accept most major insurance plans. We also match in-network benefits for those who are insured with companies we are not currently contracted with. If you have any further questions in regards to your financial responsibilities, our business office staff will be happy to assist you.

For assistance with the doctor's fees please contact their office. For questions regarding the anesthesiologist fees please contact OAG at 503-299-9906.

We hope you will find the care you receive at South Portland Surgical Center a pleasant experience. The staff is grateful to care for you or your family member and hope for a smooth and speedy recovery.

Sincerely,

The Physicians and Staff of South Portland Surgical Center

COVID-19 INFORMATION

Preparing for Surgery

To help minimize risk of asymptomatic spread of coronavirus prior to your procedure we ask that you:

- Follow physical distancing and handwashing guidelines. This also applies to the person who will be bringing you to and from surgery.
- Self-check for symptoms daily prior to surgery. Notify us if you or anyone in your household has had any of the following symptoms in the last 14 days:
  - Fever over 100.4^0
  - Chills
  - Muscle Pain
  - Recent Onset Cough
  - Shortness of Breath
  - Sore Throat
  - New Loss of Taste or Smell
  - Other Acute Respiratory Symptoms

Testing/Screening Needed

- Pre-op call: One of our nursing staff members will reach out to ask you about potential COVID symptoms and do an extensive health history questionnaire with you 2-3 days prior to surgery.
- Pre-op testing: COVID testing is no longer required prior to surgery. Your doctor may also send you for additional testing (bloodwork or an EKG) prior to surgery based on your age and medical history.

What to Expect the Day of Surgery

We have some guidelines in place that you will see immediately upon arriving at our facility.

- As of April 3, 2023, Masks are **OPTIONAL** for all patients, visitors, and medical staff.
- We are allowing visitors to accompany each patient to the facility. However, only **ONE** visitor will be allowed in the recovery unit with the patient at a time.
- If your visitor/driver would prefer to wait offsite or in their car, they may drop you off for your surgery at the main entrance. There are restrooms available for visitors on the second floor.
- If you need assistance locating our building, please call us and we can have someone meet you outside to assist you.
- We will ask for contact information for your driver at check-in. Our surgical staff will contact your driver after your surgery. They can call the front desk if they have questions at 503-218-1105.
- After surgery you will recover in our post anesthesia care unit (PACU), where they will take excellent care of you until you are ready to go home.

Please know we genuinely care about you and will do everything we can to provide you with the safest and best possible care experience. If you have any questions or concerns prior to that day, please do not hesitate to contact us at 503-218-1105.

Following Surgery: If you develop symptoms as described above, please contact your PCP. If you test positive for COVID-19 within 4 weeks of surgery, please contact us immediately at 503-218-1105.

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REGISTRATION FORM

Date _____

Last Name _____ First Name _____ MI _____

Address _____
(Street) (City) (State) (Zip)

Mailing Address _____
(City) (State) (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

SSN _____ Date of Birth _____ Marital Status M S W

Employer _____ Occupation _____

Email Address _____

In case of emergency, contact:

Name _____ Relationship _____

Daytime Phone # _____ Cell Phone # _____

Responsible Party (if not patient):

Last Name _____ First Name _____ MI _____

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Medical Insurance Information (please fill out COMPLETELY):

Primary Insurance _____ ID# _____ Group # _____

Subscriber _____ Subscriber DOB _____

Relationship to patient _____ Employer _____

Secondary Insurance _____ ID# _____ Group # _____

Subscriber _____ Subscriber DOB _____

Relationship to patient _____ Employer _____

Tertiary Insurance _____ ID# _____ Group # _____

Subscriber _____ Subscriber DOB _____

Relationship to patient _____ Employer _____

Workers Compensation / L&I Information (please fill out COMPLETELY):

Employer Name where injury occurred _____

Address _____
(Street) (City) (State) (Zip)

Work Phone # _____ Workers Comp Insurance Company _____

Address _____
(Street) (City) (State) (Zip)

Phone #_____ Date of Injury _____ Claim# _____

Adjuster Name _____ Phone # _____

Motor Vehicle Accident / Third Party Liability / Lawsuit (please fill out COMPLETELY):

Insurance Company _____

Address _____
(Street) (City) (State) (Zip)

Phone # _____ Name of Subscriber to Policy _____

Claim # _____ Date of Accident _____

Adjuster Name _____ Phone # _____

Name of Attorney _____ Phone #_____ Fax #_____

Address of Attorney _____
(Street) (City) (State) (Zip)

If other, address to send claim to _____

Release of Information and Conditions of Admission
(patient initial by each consent)

Initials

_____ **1. Release of Information**
I hereby authorize SPSC, LLC to provide all of the patient's recorded information included in the medical record to the patient's insurance company.

_____ **2. Transfer of Information**
I hereby consent to the release and transfer of records in the unlikely event it becomes medically necessary for transfer of patient to hospital while in the care of SPSC, LLC. I further consent to the release of the hospital discharge records to SPSC, LLC upon discharge from the hospital.

_____ **3. Authorized Personnel/Imaging**
I hereby authorize any personnel previously approved by my surgeon and SPSC, LLC management to be in the operating room. I consent to imaging in the event it is necessary, of my person or portion of my body or organs being taken during my procedure by my physician or a designee approved by my physician for the purpose of medical treatment. I consent that these images will become a part of my medical record.

_____ **4. Authorized Research/Education**
I hereby authorize to the use of my medical records for the purpose for research/education, provided my identity is not revealed or any descriptive texts accompanies them.

_____ **5. Assignment of Benefits**
I hereby authorize my Insurance company to make payment directly to South Portland Surgical Center, LLC for the medical and surgical benefits allowable and otherwise payable to me under the current insurance policy. I have received a copy of the Financial Agreement.

_____ _____ _____
Patient or Authorized Representative Signature Date Time

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SOUTH PORTLAND SURGICAL CENTER

FINANCIAL / BILLING POLICY

Please read the following information carefully as it applies to your financial responsibility.

Thank you in advance for your cooperation.

Understanding Your Insurance

Your medical insurance policy is a contract between you and your insurance carrier and South Portland Surgical Center is not a party to that contract. As a result, your coverage and responsibilities are determined by your policy and you are responsible for understanding and following their procedures. On your behalf, the Center will submit all your claims to your primary, secondary and tertiary insurance providers.

It is your responsibility to provide us with sufficient, accurate and up-to-date insurance and mailing address information. If your insurance carrier does not submit payment, you are liable for your entire account balance. It is your responsibility to contact your insurance carrier with any questions and to respond to any inquiries from them in a timely manner regarding your condition or procedure.

The Cost of Your Procedure

Once we receive your scheduling and insurance information from your surgeon's office, South Portland Surgical Center will contact your insurance carrier and verify eligibility and medical coverage for services at an Ambulatory Surgery Center.

Co-Payments, Deductibles and Estimated Co-Insurance amounts are due on the day of your surgery. If there is any anticipated patient responsibility you may be contacted by a Financial Coordinator to discuss these estimated costs before your scheduled procedure. If you have any questions, please call the business office at 503-218-1105.

Please note: You may receive up to 5 separate bills associated with your surgery. These include the Facility Fee, Surgeons Fee, Anesthesiologist Fee, Pathology/Lab Fee and Durable Medical Equipment (DME) if applicable.

Payment Responsibility

After your insurance has been billed, you remain responsible for the full balance. You will receive a statement in the mail and payment is due in full within 30 days. For your convenience we accept Cash, Check, Cashier's Check, Money Order, Visa, Mastercard, Discover, American Express and CareCredit. (There will be an NSF Charge for any Returned Checks).

If you are not covered by medical insurance or choose not to utilize your medical insurance for your surgery, our Center's policy requires payment in full on the day of your procedure. Please contact the Business Office Manager regarding your potential out of pocket costs.

Collections

If balances are not paid in full within 90 days or payment arrangements have not been made with the Financial Coordinator, your account may be referred to a formal collection agency. By signing below, you understand you are solely responsible for all costs, including attorney fees incurred by an outside agency in the collection of the outstanding debt.

Minors

A parent or legal guardian must accompany a minor and consent to treatment, unless otherwise stipulated by law. Parents or legal guardians must comply with the terms of this billing policy. If the parents of a minor are separated/ divorced, the Center has the right to require legal documentation determining which parent is financially responsible for paying the child's medical expenses or responsibility for determining the child's medical care needs. The parent or guardian that accompanies the minor to an office visit will be held responsible for payment of services should any dispute over payment arise.

Pre-Authorization/Pre-Certifications

If your medical insurance plan requires you to have a prior authorization or pre-certification to be on file for a procedure, this should be obtained before your scheduled procedure. The Center makes every attempt to follow-up with your physician's office to see that the authorizations are obtained prior to the surgery; however, the authorization must be obtained by the performing physician.

IF WE DO NOT HAVE THE REQUIRED PRIOR AUTHORIZATION OR PRE-CERTIFICATION; YOU WILL BE FULLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THE CENTER.

I have read and acknowledged the Financial/Billing Policy of South Portland Surgical Center and agree to the policies and patient responsibilities.

_____
Patient or Authorized Representative

_____ _____
Print Patient Name Date

Example:

Please fill out this worksheet as much as possible. Below are examples of how your worksheet should look.

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PATIENT MEDICATION RECONCILIATION

Include OTC, Herbals and Dietary Supplements

Drug Name	Dose	Frequency	Date/Time Last Dose	Route	Purpose for Use
Atenolol	25 mg	daily	2/12/18 0500am	oral	Blood Pressure
Albuterol inhaler	2 puffs	as needed	2/10/18 1200pm	inhaler	asthma
Nicotine patch	21 mg	daily	2/12/18 0600am	topical	quit smoking
Ibuprofen	200mg	as needed	2/11/18 7pm	oral	pain
Multivitamin	1 tablet	daily	2/12/18 0900am	oral	health

Drug **Allergy:** Penicillin Reaction: Rash
Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____

Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____

Patient Signature (or Responsible Party) Jane Doe

Ordered at Discharge

Drug Name	Dose	Frequency	Last Dose	Route	Purpose for Use

Sources of Information (check all applicable):

❑ Patient/Family recall

❑ Other (specify): _____

Date/Time initiated/Nurse _____

Post-op RN _____

❑ Patient may resume all medications with the exception of:

_____

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PATIENT MEDICATION RECONCILIATION

Include OTC, Herbals and Dietary Supplements

Drug Name	Dose	Frequency	Date/Time Last Dose	Route	Purpose for Use

Drug **Allergy:** _____ Reaction: _____ Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____ Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____ Drug **Allergy:** _____ Reaction: _____

Patient Signature (or Responsible Party)_____

Ordered at Discharge

Drug Name	Dose	Frequency	Last Dose	Route	Purpose for Use

Sources of Information (check all applicable):

❑ Patient/Family recall

❑ Other (specify): _____

Date/Time initiated/Nurse _____

Post-op RN _____

❑ Patient may resume all medications with the exception of:

_____

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DEEP VEIN THROMBOSIS (DVT) RISK ASSESSMENT

Please answer the following questions so we can best determine if you may be at risk for Deep Vein Thrombosis.

YES	NO		YES	NO	
☐	☐	Are you 60 years of age or older? (Y=2 N=1)	☐	☐	Are you immobile? (Move less than 100ft 3 times a day) (2)
☐	☐	Do you have a history of blood clots, blood disorders or pulmonary emblous? (3)	☐	☐	Do you have a history of a heart attack, congestive heart failure or atrial fib? (3)
☐	☐	Do you have a history of leg swelling, leg ulcers, or varicose veins? (1)	☐	☐	Have you had cancer/chemo? (past/present) (3)
☐	☐	Are you having lower extremity surgery? (5)	☐	☐	Are you currently pregnant or postpartum less than 1 month? (1)
☐	☐	Do you have inflammatory bowel disease? (Crohn's Disease,Colitis) (1)	☐	☐	Do you have a history of a stroke, paralysis, and/or MS? (5)
☐	☐	Are you taking birth control or on hormone replacement therapy? (1)	☐	☐	Do you have a bleeding or clotting disorder? (3)
☐	☐	Do you have a port-a-cath or central line in place? (1)	☐	☐	Are you a smoker, have lung disease or recent pneumonia? (2)
☐	☐	Are you overweight? (slightly, moderately, extremely) (1)	☐	☐	Do you have a splint/cast that prevents limb movement and have been wearing it for more than 30 days? (1)
☐	☐	Have you had a recent trauma?(Fall, car accident, broken bones or spinal cord injury) (5)			

_____ _____

Patient Signature Date

OFFICE USE ONLY

☐ ☐ Major Surgery, longer than 1 hour? (Y=2, N=1)

TOTAL DVT RISK FACTOR SCORE: _____

☐ LOW RISK:	0-1	(Risk Proximal DVT 0.4%)	Recommended: Early ambulation 3 x daily > 100ft
☐ MOD RISK:	2	(Risk Proximal DVT 2-4%)	Recommended: SCD
☐ HIGH RISK:	3-4	(Risk Proximal DVT 4-8%)	Recommended: SCD
☐ VERY HIGH RISK:	5+	(Risk Proximal DVT 9-20%)	Recommended: SCD

FALL RISK ASSESSMENT

RISK FACTORS:	LEVEL	SCORE
Recent falls (within the past 3 months)	Low	2
Frequent falls (3 or more)	Moderate	4
Visually impaired, hx of stroke	Moderate	4
Uses cane or crutches	Moderate	4
Uses a walker or wheelchair	Moderate	4
Hx of inability to stand alone, unsteady gait	Severe	8
(Antihistamines, antihypertensives, diuretics)	1-2 medicatic	2
(Antiseziure medication, sedatives, hypnotics)	1-2 medicatic	4

(Low Risk= 0-4 Mod Risk=5-8 High Risk=9+)

TOTAL SCORE:_____ PT RISK: _____

FALL RISK BRACELET PLACED ON PATIENT ☐YES ☐NO

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PRE-ANESTHESIA QUESTIONNAIRE

Please answer the following questions so we can best tailor your anesthetic to your specific needs. Most people tolerate anesthesia very well. There are risks associated with anesthesia which rarely cause permanent injury or death. We would be happy to answer any questions regarding your anesthetic options or risks.

Height _____ **Weight** _____ **lbs** _____ **Kg** **BP** _____ **HR** _____ **SAT** _____ **Temp** _____

Have you had:	**Circle Answer**	
Surgery or anesthesia before	Yes	No
List surgeries _____		
_____		
_____		
_____		
Bad reactions to anesthesia (for example severe sore throat, nausea, or difficult intubation)	Yes	No
Relative with bad reaction to anesthsia (for example, malignant hyperthermia)	Yes	No
High blood pressure	Yes	No
Heart problems (abnormal rhythm or EKG, chest pain)	Yes	No
Breathing problems (asthma, heavy snoring, sleep apnea emphysema, abnormal chest x-ray)	Yes	No
Recent or current infection (cold, flu, communicable disease)	Yes	No
Liver problems (jaundice, hepatitis)	Yes	No
Bleeding problems or blood clot	Yes	No
History of Anemia	Yes	No
Kidney problems	Yes	No
Stomach or intestinal problems (heartburn, reflux, ulcers, hiatal hernia)	Yes	No
Diabetes (If yes, Insulin ___ Diet ___ Oral agent ___)	Yes	No
Neurologic problems (seizure, stroke, numbness, weakness)	Yes	No
Neck or jaw problems	Yes	No
Back problems or chronic pain	Yes	No
Joint problems or artificial joints	Yes	No
Cancer or chemotherapy	Yes	No

Do you:	**Circle Answer**	
Take medications?	Yes	No
List: _____		
_____		
_____		
_____		
Have allergies or reactions to medicine, latex, tape, eggs or iodine?	Yes	No
List: _____		
_____		
_____		
_____		
Smoke? Packs per day_____ for_____ yrs.	Yes	No
Quit when? _____		
Drink alcohol (more than occasionally)	Yes	No
Use recreational drugs?	Yes	No
Have any implanted electronic device, such as a pacemaker?	Yes	No
Wear contact lenses?	Yes	No
Have artificial lens or eye?	Yes	No
Have trouble hearing?	Yes	No
Have loose / removable teeth?	Yes	No
Have objection to a blood transfusion even in life threatening situations?	Yes	No
Female: Are you pregnant or nursing?	Yes	No

When did you last eat or drink? _____ am/pm
(On day of surgery)

Primary physician is: _____

Other medical problems, illnesses or injuries? Explanation or comments:

_____

_____

_____

Patient Signature_____
(or responsible party)

Date _____ **Time** _____

Oregon Anesthesiology Group
Consent for Anesthesia Services

This form is informational and meant to provide you with specifics about possible anesthetic services and anesthetic outcomes for your upcoming procedure. Please read this form thoroughly and if you have any questions or concerns please bring them up during your pre-operative phone call or on the day of surgery with your OAG anesthesiologist. A similar form will be provided on the day of your procedure and will be signed by you and your anesthesiologist after an in-person consultation.

You, in consultation with your physician, have decided to undergo a procedure that will require anesthesia to make it safer for the procedure to be performed and to lessen the discomfort you would otherwise experience. An anesthesiologist will be there during your procedure to monitor you while they provide specific anesthesia services. The determination of what type(s) of anesthesia services and techniques are best for you depends on factors including your physical condition, the type of procedure you are undergoing, and the preferences of you and your physician.

Even though anesthesia has become remarkably safe, all forms of anesthesia involve some risks and no guarantees can be made that you will not suffer a side effect or complication from your anesthesia. Although rare, unexpected and severe complications can occur with all forms of anesthesia, including: infection; bleeding; drug or allergic reactions; nausea; awareness under anesthesia; injury to eyes, lips, and teeth; injury to the vocal cords; respiratory/breathing problems; nerve injury with loss of sensation or function; paralysis; stroke; damage to liver, kidney, or lungs; heart attack; brain damage and even death. These risks apply to all forms of anesthesia and additional or specific risks have been identified below as they may apply to a specific type of anesthesia.

Anesthesia may have additional risks during pregnancy. In early pregnancy anesthesia medications may alter the development of the unborn child. If an operation for another medical condition while pregnant is required, labor may start before it would have otherwise.

Sometimes an anesthetic technique that involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may need to be used to keep you safe, including general anesthesia.

General Anesthesia	Expected Result Technique Risks	• Total unconscious state, possible placement of a tube into your airway/windpipe • Medication injected into the bloodstream, breathed into the lungs, or by other routes • Injury to mouth, teeth, or throat, hoarseness or throat pain, awareness under anesthesia, aspiration, pneumonia, nausea, vomiting, injury to blood vessels
Monitored Anesthesia Care (with sedation)	Expected Result Technique Risks	• Reduce anxiety and pain, partial or total amnesia • Medication injected into bloodstream, breathed into the lungs, or by other routes to produce a semi-conscious state • Depressed breathing, injury to blood vessels
Monitored Anesthesia Care (without sedation)	Expected Result Technique Risks	• Measurement of vital signs, Anesthesiologist availability for further intervention • None • Awareness, anxiety, discomfort
Nerve Block	Expected Result Technique Risks	• Temporary loss of feeling and/or movement of a specific area or limb • Medication injected near nerves providing loss of sensation to the area of operation • Persistent numbness or weakness, nerve injury, infection, residual pain, convulsions, injury to blood vessels, failed block
Spinal or Epidural	Expected Result Technique Risks	• Temporary decreased/loss of feeling or movement of the lower part of the body • Medication injected through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal • Headache, backache, infection, persistent weakness/numbness, residual pain, injury to spinal cord, convulsions, injury to blood vessels, unconsciousness

I consent to the service(s) checked above. I also consent to the alternative types of anesthesia, if necessary, as deemed appropriate by the Anesthesiologist. I understand the importance of providing my health care providers with a complete medical history including medications both prescription and over the counter. I understand that I may have other health issues that increase my risk of complications under anesthesia. I understand that my use of herbal remedies, alcohol, marijuana, or any type of illegal drug may give rise to serious complications and must also be disclosed. I also understand that I should disclose any complications that arose from past anesthetics. I acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia services and that I have had the time and opportunity to ask questions and to consider my decisions.