SOUTHWEST COLORADO SURGERY CENTER

20 South Beech Street
Cortez, CO 81321
Phone: (970)565-1400
Fax: (970) 564-1655

PROCEDURE: ____________________________ **PROCEDURE DATE:** ____________________________

SURGEON: ______________________________ **REF PHYSICIAN:** ______________________________

Patient Name: ____________________________________ **DOB:** _____________ **Age:** _________________

Address: ____ **City/State:** _______________ **ZIP:** _____________

Home Phone Number: ______________________ **Cell Phone Number:** ______________________________

Employer: _________________________________ **Phone:** ____

Emergency Contact: _________________________ **Phone:** ____

Insurance: **see attached** **Policy Holder:** **see attached**

ID Number: ______________________________ **Group:** ____

State of Responsibility, Assignment of Medical Benefits & Authorization for Release of Information

I agree that if my insurance carrier does not pay in full for services received through Southwest Colorado Surgery Center, that I am personally responsible for payment of this full balance within 30 days of billing. In the event my personal balance becomes delinquent and further collection efforts are necessary, I agree to pay all costs and reasonable attorney's fees incurred by Southwest Colorado Surgery Center in said collection efforts. My signature below represents my understanding and acceptance of this policy.

I understand that Southwest Colorado Surgery Center is released from all responsibility for loss or damage to personal property retained in patient's possession.

I authorize direct payment to Southwest Colorado Surgery Center of all medical benefits applicable to my treatment at the Surgery Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize the release by Southwest Colorado Surgery Center any medical information necessary to process any claim or appeal on my behalf.

Patient Signature: ____

Date: ____

SOUTHWEST COLORADO SURGERY CENTER

Patient Consent to be Contacted

NATIONAL ENDOSCOPIC DATABASE

William G. Rainer, Jr., MD, FACS
David A. Lieberman, MD

I consent to have an investigator affiliated with the National Endoscopic Database call me to discuss my participation in future research studies related to the examination I will undergo today. I know that I will be called only if I qualify for a research study. If I do not qualify for a future study, I will not be contacted.

I understand that by signing this I am not obligated to participate in future research studies, and I may refuse to participate in any of these research projects when they are explained to me.

I also understand that I can change my mind in the future and take back (rescind) this consent to be contacted by an investigator by calling the Clinical Outcomes Research Initiative at 503-494-7401, or by sending a letter addressed to the:

Clinical Outcomes Research Initiative
Mailcode: CH15C
Oregon Health & Science University
3181 SW Sam Jackson Park Road
Portland, Oregon 97239

If I decline to have an investigator call me, this will not affect my medical care at this hospital or clinic in any way.

I will be given a copy of this consent form.

The research is funded by the National Institutes of Health with support from industry sponsors.

Signature: ____

Printed Name: ____

Date: ___________________________

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CONSENT FOR TRANSFER

In the event transfer to another facility is required emergently I hereby authorize **Southwest Colorado Surgery Center** to arrange transfer by ambulance if ordered by **William G. Rainer, Jr., MD.**

Transfer will be to **Southwest Memorial Hospital or another appropriate facility of your physician's choice.**

Patient Signature: ____

Date: ____________________________

Witness to Patient Signature: ______________________________________

Date: ____________________________

SPEAK UP ACT

At Southwest Colorado Surgery Center we want to encourage all of our patients to take an active role in their care plan. We want our patients to speak up about any safety concerns or preferences in their care that they might have. If there is something you feel you would like to address, please speak with your nurse at the time or you may contact our Director of Nursing, Mical Rainer, either here at the Surgery Center or by calling her at (970) 565-1400 at a time convenient for you. If you still feel your concern has not been properly addressed you should also feel free to contact the Montezuma County Public Health Department, which can be reached at 106 W. North Street, Cortez, CO or at (970) 565-3056.

Printed Name of Patient: ____

______________________________ ______________________________

Signature of Patient Date

____

Signature of Patient Representative (if patient is minor or adult unable to sign)

____

Relationship of Patient Representative to Patient

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Acknowledgement of Receipt of Notice of Privacy Practices

Southwest Colorado Surgery Center is a limited liability corporation and reserves the right to modify the privacy practices outlined in the notice. By signing below you acknowledge that you have received this notice, you understand your physician may be an investor/ owner, and that you selected to use the Surgery Center as your facility of choice. You further acknowledge that you understand it is your right to ask your physician for an alternative location should you choose.

Southwest Colorado Surgery Center is owned and managed by a group of partners who include:

- Bill Rainer, MD
- W. Gerald Rainer, MD
- Valden Johnson, MD
- Thomas Willis, MD
- Ms. Nora Bell

I have received a copy of the Notice of Privacy Practices for Southwest Colorado Surgical Center.

Printed Name of Patient: ____

______________________________ ______________________________
Signature of Patient Date

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Permission to Discuss your Care

You will receive sedation or anesthesia before your surgery. Therefore, you will need a responsible adult to drive you home.

Please list name and telephone number of the person driving you home.

Is it permissible for the doctor and nursing staff to discuss your care with the person listed below?

___________Yes ___________No

Name: ____

Telephone number: ___________________________

Printed Name of Patient: ____

______________________________ ______________________________
Signature of Patient Date

____
Signature of Patient Representative (if patient is minor or adult unable to sign)

Relationship of Patient Representative to Patient: ______________________________________

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surgerycenter@swcsc.org

PATIENT FINANCIAL RESPONSIBILITY CONTRACT

We are dedicated to providing the best care and service to you with as little hassle as possible. We regard your understanding of your financial responsibilities as essential to your treatment and care. We have adopted this financial policy to reduce confusion and misunderstandings between our patients and our facility. If you have any questions please do not hesitate to discuss them with our Medical Director. The Surgery Center of Southwest Colorado appreciates the confidence you have shown in choosing us to provide your healthcare needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance on your behalf. However you are ultimately responsible for payment of your bill.

Please read and initial each paragraph, then sign to acknowledge your understanding and acceptance.

1. ______ I understand and accept that ultimately I am responsible for all services provided to me by SCSC. I understand and agree to pay for all services provided, **at time of service**, unless they are covered by a contracted insurance company.

2. ______ I understand and accept that SCSC will verify my coverage and bill my insurance(s), but that if I have a co-pay and/or deductible, I agree to pay in full **at time of service**.

3. ______ I understand and agree to pay any co-insurance **within 30 days** of my first statement from SCSC, unless prior arrangements have been made with the Medical Director.

4. ______ I understand and accept that I will be assessed a fee of $20.00 plus any additional charges allowed by CRS 13-21-109 for any returned check. Thereafter, any payments will need to be made in cash or by credit card.

5. ______ I understand and accept that if, after 90 days after billing, my insurance has not paid, my account will be due and I will be responsible for payment in full of any outstanding balance.

6. ______ I understand and accept that if I do not have insurance or want to self pay, payment will be due **at the time of service**, unless prior arrangements have been made with the Medical Director.

Printed Patient's name: ____

Patient's signature: ____ Date: ________________

Witness' signature: ____ Date: ________________

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Patient Satisfaction Questionnaire

We have tried to make your Ambulatory Surgery Experience as comfortable as possible. We are striving for perfection and, therefore, need your assessment of our services, personnel, and facility. Please complete this questionnaire and return it to us. Thank you.

- Do you feel that your instructions prior to surgery were adequate? Yes No
- Do you feel the Surgical Center personnel were interested in you as a person? Yes No
- Was the Surgery Center pleasant and comfortable? Yes No
- Do you feel that the separation from your family member or friend was minimal? Yes No
- Do you feel that you had been given adequate postoperative instructions? Yes No
- Do you feel that your nurse washed his/ her hands between patients? Yes No
- If you would have surgery again, would you consider returning to our facility? Yes No
- Would you recommend this hospital to your friends? Yes No
- If Southwest Colorado Surgery Center were not available where would you go?
  1) Southwest Memorial Hospital 2) Mercy Medical Center 3) Animas Surgical Hospital 4) San Juan Regional Medical Center 5) Northern Navajo Medical Center 6) Other
- How would you rate your overall experience? [] Excellent [] Good [] Fair [] Poor
- How did you hear of us? Referral by: _________________ Advertisement (where): _______________

  Phone Bk. (which one): _________________ Internet [] Other: __________________

Please list any general comments or suggestions you feel will help us to improve the quality of patient care at our facility.

____

____

Date of Surgery: ____________________________ Name (optional) _____________________________