THE CENTER FOR AMBULATORY SURGERY
1450 ROUTE 22 WEST
MOUNTAINSIDE, NJ 07092

Consent for Procedure/Treatment

TO THE PATIENT: You have been given information about your condition and the recommended surgical, medical, or diagnostic procedure(s) to be used. This consent form is designed to provide a written confirmation of such discussions for recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s)

1- Condition:	Dr. _____ has explained to me that the following medical / conditions exist in my case: (Explain in lay terms): _____
2- Proposed Operation / Procedure(s):	I understand that the operation/procedure(s) proposed for evaluating and treating my condition is (are): This is a **Right** **Left** **Bilateral** (circle one) sided surgery. If it is the spine, there is no need to preoceed further with this section. If yes, Items 1, 2, 3 must be completed 1. Patient Identification has taken place. □ Yes 2. Surgeon must attest by signature and date (below) that the above has taken place. 3. Correct side has been indelibly marked. □ Yes 4. Patient validated **Right** **Left** **Bilateral** side
3- Risks / Benefits of Proposed Procedure(s):	Just as there may be benefits to the procedure(s) proposed, I also understand that surgical, medical and dental procedures involve risks, alternative, and benefits. These risks include allergic reactions, bleeding, blood clots, infections, and even loss of bodily function or life.
4- Complications, Unforeseen Conditions, Results	I am aware that in the practice of medicine and surgery, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s), unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedure to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.
5- Acknowledgement	I understand that: A. The potential benefits and risks of the proposed procedure(s), the alternatives, and the likely result without such treatment have been explained to me. B. I am aware and agree to have a Resident assisting the surgeon and to take pictures / video of the procedure for educational purposes as long as my face/recognizable body parts are concealed. C. I am aware and agree to have a technical/manufacturer/sales representative to observe my surgical procedure if that, in the judgement of the surgeon, is necessary for the positive outcome of the surgery.
6- Consent to Procedure(s) and Treatments	Having read this form and spoken with my physicians, my signature below acknowledges that I voluntarily give my authorization and consent to the performance of the procedure(s) described above (including disposal of tissue) by my Physician, and/or such assistants as may be selected by him / her. _____ Patient Signature (or person authorized to sign) _____ Surgeon Signature _____ / / Date _____ AM / PM Time _____ Relationship to Patient _____ Witness Signature _____ / / Date _____ AM / PM Time
Interpreter (If Needed)	Signature: _____

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ACCT:
DOB: AGE:
DR:
DOS:

Post Operative Disharge Instructions

Restrictions:
Do Not drive for 24 hours and whil Reactions
No alcoholic beverages for 24 hours or while on pain medications.
Do Not sign any legal documents or make any important decisions.
Do Not operate any machinery for 24 hours.
Highly Recommended you have a responsible adult with for the next 24 hours after your procedure

Activity:
- □ Rest and relax today. Do not resume usual activities.
- □ No strenuous activities. No heavy lifting.
- □ May return to work/school in _____days. No gym for _____days.
- □ Other: _____

Notify MD if:
- ** **Excessive bleeding that soaks dressing.**
- ** **Fever of 101 or greater.**
- ** **Increased redness or swelling along incision.**
- ** **Foul or pus colored discharge from incision.**
- ** **Unrelieved pain and nausea.**

Wound Care:
- □ Keep dressing dry and intact.
- □ Change dressing daily.
- □ See attached sheet.
- □ Other: _____

Bathing:
- □ Sponge bath.
- □ Shower: □ 24 □ 48 □ 72 hours.
- □ No submersions (bath, pool, hot tub)

Extremeties (upper or lower):
- □ Elevate above the level of your heart for 48 hours.
- □ Ice intermittently (30 minutes on, 30 minutes off) for 48 hours.
- □ Excercises/Range of Motion: _____
- □ Weightbearing: _____
- □ Use crutches/sling/shoe/knee immobilizer until: _____

Diet:
- □ Light diet for remainder of today. Regular diet as tolerated tomorrow.
- □ No restrictions. □ Other: _____

Medication:
- □ To control pain take the medication that was prescribed to you as instructed.
- □ Presciptions attached.
- □ Resume all usual Medications.

Next Physician Visit:
- □ Your post-operative appointment is: _____
- □ Please call Physician's office. #: _____

In a true emergency please dial 911 and go to your nearest emergency room.

Patient Signature: _____ Responsible Adult: _____

Physician: _____ Nurse: _____

Interpreter: _____

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ACCT:
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DR:
DOS:

Instrucciones Para la Dada de Alta Despues de Cirugias

Restricciones:

No conduzca por 24 horas y mientras este usando el medicamento para el dolor.
No tome alcohol por 24 horas o mientras este usando el medicamento para el dolor.
No firme ningun documento legal ni tome decisiones importantes.
No opere ninguna maquinaria por 24 horas.
Recomienda en gran medida que un adulto responsible este con usted durante las 24 horas siguientes al procedimiento

Actividad:

- □ Hoy, descanse y relajese. No vuelva a sus actividades usuales.
- □ No haga actividades agotadoras. No levante cosas pesadas.
- □ Puede regresar a trabajo/la escuela en _____days. No vaya al gimnasio durante _____dias.
- □ Otros: _____

Notifique al Medico si se presenta lo siguiente:

- ** **Sangrado excesivo que empapa el vendaje.**
- ** **Fiebre de 101 o mas.**
- ** **Aumento del enrojecimiento o la hinchazon a lo largo de la incision.**
- ** **Secrecion maloliente o de color a pus proveniente de la incision.**
- ** **Dolor y nausea que no desaparecen.**

Cuidado de la Heria:

- □ Mantenga la herida seca e intacta.
- □ Cambie el vendaje a diario.
- □ Consulte la hoja adjunta
- □ Otros: _____

El Bano:

- □ Banese con esponja.
- □ Regaderazo: □ 24 □ 48 □ 72 horas.
- □ No sumerja el area (banera, piscina, jacuzzi).

Extremidades (superiores o inferiores):

- □ Elevelas por encima del nivel del corazon por 48 horas.
- □ Aplique hielo intermitentemente (30 minutos si, 30 minutos no) por 48 horas.
- □ Ejercicios/Ramgo de movimiento: _____
- □ Aplicacion de peso: _____
- □ Use las muletas/cabestrillo/zapato/unidad de immovilizacion de rodilla hasta el:_____

Alimentacion:

- □ Alimentos ligeros durante el resto del dia de hoy. Manana alimentacion normal segun la tolere.
- □ No hay restricciones. □ Other: _____

Medicamento:

- □ Para controlar el dolor, tome_____de ser necesario. Empiece a las:_____
- □ Radiografias adjuntas:
- □ Empiece a volver a tomar todos los medicamentos usuales.

Siguiente Visita Medica:

- □ Su cita postopratoria es: _____
- □ Llame el consultorio medico. El Numero es: _____

En caso de una verdadera emrgencia, llame al 911 y vaya a la sala de emergencia mas cercana.

Paciente: _____ Adulto Responsible: _____

Medico: _____ Enfermaria: _____

Interpreter: _____

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SCHEDULING FORM / PRE-ADMISSION

SchedulingTel. # : 908-233-8577
Fax #: 908-233-5916

PLEASE PRINT CLEARLY

PROCEDURE DATE: _____ REQUESTED TIME: _____

Surgeon: _____ Assistant: _____

PATIENT'S INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____ AGE: _____

Address: _____ City & State: _____ Zip Code: _____

Gender: (Circle One) M or F SS#: _____ DOB: _____

Home Telephone #: _____ Work #: _____ Cell #: _____

If patient is a minor, Parent or Guardian's Name: _____ Patient's Email: _____

Patient Speaks English? YES NO If No, Language Spoken: _____

EMERGENCY Contact Name: _____ Relationship: _____

Phone #: _____

MEDICAL INFORMATION: (PLEASE RECORD PATIENT'S ACTUAL HEIGHT AND WEIGHT)

Anesthesia Type: (Check Off) ☐ General ☐ MAC ☐ Spinal ☐ Local

ASA CLASS _____ HEIGHT _____ WEIGHT _____ BMI _____

NOTE: ALL LABS/EKG/MEDICAL CLEARANCE MUST BE REC'D AT LEAST 1 WEEK PRIOR TO SURGERY TO AVOID POSSIBLE CANCELLATION.
IT WILL BE AT THE DISCRETION OF ANESTHESIA TO CANCEL THE CASE IF INFORMATION IS NOT REC'D OR RESULTS ARE ABNORMAL.

LAB: (Check Off) ☐ CMP ☐ CBC ☐ PT/PTT ☐ EKG ☐ CHEST X-RAY Testing Location: _____

Medical Clearance w/Dr. _____ Phone: _____

ALLERGIES: (Drug/Food/Latex /Other) _____ Fax: _____

DIAGNOSIS: _____ ICD 10 Code: _____

SITE Location: (If applicable circle one) Left Right Bilateral TIME REQ.: _____

PROCEDURE: _____ CPT Code: _____

_____ CPT Code: _____

_____ CPT Code: _____

Special Equipment/Rep Needed: _____

X-Ray: O Yes O NO Implantable Device Needed: BE SPECIFIC _____

INSURANCE INFORMATION: ** PLEASE PROVIDE A COPY OF INSURANCE CARD - BOTH FRONT AND BACK WITH BOOKING SHEET **

Type of Insurance: (Circle One) Commercial PIP W/C LOP

Primary Ins:	Secondary Ins:
ID / Claim # :	ID / Claim # :
Group # :	Group #:
Subscriber's Name:	Subscriber's Name:
SS#: DOB:	SS#: DOB:
Relationship:	Relationship:
Adjuster's Name: Benefits Phone #:	Adjuster's Name: Benefits Phone #:
DOA: (If Applicable) Precert Auth.#:	DOA: (If Applicable) Precert Auth.#:

PLEASE NOTE: THERE ARE THREE PAGES IN TOTAL
IN-NETWORK
1199 SEIU BENEFIT FUND (AETNA)
AETNA & Premier Care Network Plus Multi-Tier (card must show this exactly) *****except** *ALL Whole Health, ALL OTHER Premier Care Network*******
AETNA MEDICARE ***** ***except** Medicare Prime*****
AETNA SENIOR MEDICARE SUPPLEMENT
ALLIED BENEFIT SYSTEMS (AETNA OR CIGNA)
AMERIHEALTH TIER 1 & MEDIGAP
BAS ****see note below
BIND BENEFITS (UHC)
NORTHWELL DIRECT
CHAMP VA
CIGNA OAP, SAR, PPO, HMO, GPPO ***(**NOT** LocalPlus)***
CLOVER HEALTH HMO 002, 003 and PPO 054, 055, 004, 007 *(**NOT** PPO 001, 032, 042)* see can take
EMBLEM HEALTH (GHI)** see note below
GEHA (UHC SHARED SERVICES)
HORIZON BCBS Including all HMO, EPO, PPO and OUT OF STATE PPO
HORIZON BRAVEN MEDICARE ADVANTAGE
HORIZON OMNIA TIER I
HORIZON OMNIA RWJBARNABAS HEALTH PREMIER INNER CIRCLE
HORIZON MEDICARE BLUE ADVANTAGE HMO
HORIZON MEDIGAP SUPPLEMENT
HUMANA MEDICARE SUPPLEMENT
IAA (CIGNA); **IDA** (CIGNA); **ILA** (CIGNA and AETNA)
LOOMIS COMPANY (CIGNA)
MAGNACARE LOCAL 807 only ****FACILITY SPLITS WITH EMPIRE BCBS****

IN-NETWORK
MEDICARE
MERITAIN HEALTH (AETNA CHOICE POS II) ***(NOT** Aetna Premier Care Network)***
NALC (CIGNA)
NY SHIP ***FACILITY BENEFITS SPLIT with UHC or EMPIRE BCBS printed on card***
NORTHWELL DIRECT
OSCAR (QUALCARE contract)
QUALCARE
SAMBA (Federal Employees)
TRICARE FOR LIFE (WITHOUT Humana) (Retired Military) ***must be Medicare-age***
UMR (UNITED HEALTHCARE)
UNITED HEALTHCARE CHOICE, CHOICE PLUS /OXFORD **NOT** Medicare nor Medicaid plans**
UNITED HEALTHCARE including All Savers, Select Plus, PPO, Global, Options PPO, Passport Connect Choice Plus, AARP Medicare Advantage UHC NJ-0001, 0002, 0003, Patriot No Rx NJ-MA01 (HMO-POS); AARP MEDICARE ADVANTAGE UHC NJ-0004, 0005 (PPO) Navigate Plus **always** needs a referral
UNITED HEALTHCARE AARP MEDICARE SUPPLEMENT PLAN
WebTPA

EMBLEM HEALTH (GHI) (provider): **SPLIT PLAN** : TCFAS **absolutely** requires a copy of the card
USUALLY WITH **EMPIRE BCBS** (facility) (City of NYC on card **AND** should also have an EMPIRE BCBS card) SEND BOTH.
Or **QUALCARE** (facility) (Federal Employee on card)

****BAS** SPLIT PLAN: TCFAS **absolutely** requires a copy of the card (should PAR for facility but will need to call the number for contract shown on back of card)

*****SCHOOL INSURANCE CLAIM**: TCFAS requires a copy of commercial insurance even if it is Medicaid & make parent aware that the form needs to be faxed to SCHOOL INS. immediately

******PRP Injection is not covered by any insurance**: Patient is responsible for $400.00 on date of service

OUT-OF-NETWORK & CAN TAKE
CIGNA LocalPlus with Out-of-Network Benefits
CLOVER HEALTH PPO 001, 032, 042 **out-of-network copay will apply**
HUMANA MEDICARE with Out-of-Network Benefits
MAGNACARE ***NEED to confirm out-of-network benefits and **MUST** be approved by the Union
MULTIPLAN with Out-of-Network Benefits
TRICARE PRIME with Humana (Active Military) with Out-of-Network Benefits & Must be Authorized **NO IMPLANTS** (VERY HARD TO GET APPROVED)
TRICARE EAST (RETIRED MILITARY YOUNGER THAN MEDICARE) with Out-of-Network Benefits **NO IMPLANTS**
TRICARE EAST RESERVE CONNECT/SELECT with Out-of-Network Benefits **NO IMPLANTS**
WELLCARE with Out-of Network Benefits

TCFAS DOES NOT PAR
AETNA BETTER HEALTH
AETNA WHOLE HEALTH, PREMIER CARE NETWORK, MEDICARE PRIME
ALIERACARE
CLOVER HEALTH
HORIZON NJ FAMILY CARE
MEDICAID (Primary nor Secondary)
UNITED HEALTHCARE DUAL COMPLETE
******NOTE: CVS EMPLOYEES WITH AETNA COVERAGE LIKELY TO BE WHOLE HEALTH****** **CVS CAREMARK EMPLOYEES ARE LIKELY TO BE OK WITH AETNA**