



505 Sir Francis Drake Blvd.
Greenbrae, CA 94904
T: 415-461-4400 F: 415-461-4484

Spine Care Packet

➤ **Read / Keep: Informational Documents 1-6D**

1. Patient Welcome Letter
2. Required Federal Information & Check List
3. Advanced Directive / Living Will Information
- 4A Patient Rights and Responsibilities
- 4B Notice of Privacy Practices
5. Insurance & Billing Information
- 6A Scheduling, Directions, Telephone Numbers
- 6B Common Procedure Instructions & Information
- 6C Corticosteroid Notes
- 6D Medication Notes

➤ **Return Forms: 7-10**

7. **Patient Questionnaire** (2 pages): MSSC would like to receive this as soon as possible. You can Fax, Mail, or Hand Carry it into MSSC before or on your date of service if you are unable to return it before we see you for your procedure.
8. **Patient Acknowledgement Letter**: If you receive this packet from your doctor, please sign and return it to their office. They will fax it back to us. If didn't receive our packet from your doctor, see Other Return Options below. It is important that you receive this disclosure information before your procedure.
9. **Acknowledgement of Receipt of Privacy Practices**
10. **Patient Population Survey**

➤ **Return Options...**

- Fax to the RN pre op Desk: 866-425-0414
- Hand carry it in to MSSC any time prior to OR on your procedure date.

Please contact us if you have any questions.
Thank you for choosing the Marin Specialty Surgery Center.
We look forward to taking care of you.



Dear Patient:

Welcome to Marin Specialty Surgery Center. We are pleased that you have placed your trust in us for your healthcare services.

We want to provide an atmosphere of compassion and understanding with minimal stress to our patients.

In the days before your procedure, you will be contacted by a representative from our Business Office to discuss your insurance coverage, and financial responsibilities to Marin Specialty Surgery Center. This conversation will cover co-pays, deductibles, and co-insurance payments. Please do not hesitate to ask for clarification on any of these matters during this telephone call.

NOTE: you will not receive a call if we do not expect you to have a payment due, or have Medicare coverage.

Our policies ask that you arrange for a responsible adult to take you home from the center if you receive sedation. Your designated adult driver should be on hand to help you receive post-procedure instructions, take you home and be available to you at least overnight after your procedure. You **will not** be permitted to drive yourself home after receiving sedation for your safety.

- **Remember the 567 Rule:** No anticoagulants for **5** days, nothing to eat or drink for **6** hours, and no NSAIDS (non steroidal) for **7** days prior to your procedure. (See page 6d for detailed list)
- If you are on anticoagulants/blood thinners (such as Coumadin, Warfarin) you will need to get a protime blood draw **1** business day before your procedure. Please have the lab results faxed to 415-496-2244. If you get it done the morning of your procedure make sure the lab knows that it is a STAT order. If you have questions regarding this process please contact your doctor's office.

When you come to Marin Specialty Surgery Center, we ask that you do not bring any jewelry or other valuables to the center. We do ask that you bring your Government issued I.D.(driver's license or passport) and insurance card(s) with you as well as your advance payment for co-pays or deductibles based on your conversation with our business office.

If at any time during your visit you have a question regarding a process or your safety, we ask that you speak up and share your concerns with our staff. Our goal is to provide a safe, friendly environment in which your concerns are addressed promptly to your satisfaction.

In closing, we appreciate the trust you have placed in us. We will make every attempt to honor that trust by providing the high quality medical care you expect and deserve. We want your visit to be as pleasant as possible under the circumstances and welcome any comments and suggestions you may have.

If you have any further questions, please call us at 415-461-4400. One of our Marin Specialty Surgery Center team members will be happy to assist you.

Sincerely,

Justin Dy, RN, BSN, CNOR
Administrator

Dear Patient,

Thank you for choosing to have your surgery with us at the Marin Specialty Surgery Center.

PLEASE HELP US TO BETTER SERVE YOU BY COMPLETING AND RETURNING THE FOLLOWING REQUIRED INFORMATION

- Pre-op Questionnaire # 7 (2 pages)
- Pt. Acknowledgement Letter #8
- Acknowledgment of Receipt of Privacy Practices..... # 9
- Patient Population Survey..... #10

Return Options...

- Fax to the RN pre op Desk: 866-425-0414
- Hand carry it in to MSSC any time prior to OR on your surgery / procedure date

Federal regulations require that we inform you of the following important issues and that we confirm with you that you have received the information BEFORE your date of service. We will verify such on your preoperative call.

- **PATIENT RIGHTS & PRIVACY PRACTICES:** Your rights as a patient at a healthcare facility. Enclosed is a description of the Patients Rights and Responsibilities as well as our Privacy Practices.
- **ADVANCED DIRECTIVE INFORMATION (LIVING WILL / HEALTHCARE PROXY):**
 The Marin Specialty Surgery Center's policy on Advanced Directives is as follows:
 - You have the right to make choices regarding life-sustaining treatment, including resuscitative measures.
 - As your procedure here is elective, MSSC cannot withhold treatment if an unexpected complication were to arise.
 - If there is a need to transfer you to a hospital for additional care measures beyond what we can provide, your Advance Directive will be in your record and honored at the hospital or with your next caregiver upon your arrival.
 - **We are required** to inquire about your legal directives regarding your medical care. However, **you are not required** to present an Advance Directive document before you have surgery in an ambulatory care surgery center.
 - Enclosed in your packet is a description of applicable State health and safety laws with resources for you to obtain your own copy.
 - **Please do not bring a blank Advanced Directive form to the Center - it must be completed and witnessed prior to your surgery if you wish to include it in your patient record.**
- **PHYSICIAN OWNERSHIP:** Your surgeon may be a principal, or physician investor, in the Marin Specialty Surgery Center, which is a partner of Surgical Care Affiliates. We are accredited by The Accreditation Association for Ambulatory Health Care, AAAHC. This official endorsement assures you of our commitment to meeting rigorous, nationally recognized standards for quality health care services. We want to offer our patients a compassionate, safe, cost-effective, alternative to hospital-based care. Over forty surgeons are privileged on our medical staff; 27 of whom are limited physician partners. While MSSC has been recommended, the choice of where you would like to have your surgery is solely yours. If you would like us or your physician to provide you with alternative venues for your surgery, please speak up and we will inform you about other out-patient surgery choices.

Read / Keep: Informational Documents

- 1 Patient Welcome Letter
- 2 Required Federal Information & Check List
- 3 Advanced Directive / Living Will Information
- 4A Patient Rights and Responsibilities
- 4B Notice of Privacy Practices (3 pages)
- 5 Insurance & Billing Information
- 6A Scheduling, Directions, & Telephone Numbers
- 6B Common Instructions & Information
- 6C Corticosteroid Notes
- 6D Medication Notes

Return: Fax or Hand Carry * See instructions above*

- 7 Pre-op Questionnaire (2 pages)
- 8 Patient Acknowledgement Letter*, a receipt of above federal required information
- 9 Acknowledgment of Receipt of Privacy Practices
- 10 Patient Population Survey

The amount of paperwork a patient has to sort through is often confusing and frustrating.

Hopefully this check list will help you with it. If you have any questions or concerns, please contact our office at (415) 461-4400

Justin Dy, RN, BSN, CNOR
Administrator



Information Regarding Advance Directives

An "advance health care directive" or "living will" lets your physician, family and friends know your health care preferences, including the types of special treatment you want or don't want at the end of life.

By considering your options early, you can ensure the quality of life that is important to you and avoid having your family "guess" your wishes or having to make critical medical care decisions for you under stress or in emotional turmoil.

This legal document describes how you feel about care intended to sustain life. You can accept or refuse medical care. There are many issues to address, including but not limited to:

- The use of life sustaining machinery (Ventilators, Dialysis)
- Whether or not you want to be resuscitated if breathing or heartbeat stops
- Tube feeding and other life sustaining processes
- Organ or tissue donation

A durable power of attorney for health care is another legal document that names your health care proxy. Your proxy is someone you trust to make health decisions if you are unable to do so.

While all of these documents play a very important role in how healthcare decisions are made on your behalf, it is the policy of Marin Specialty Surgery Center that we **DO NOT** honor Advance Directives during your episode of care at our facility.

If you have completed Advance Directive, please bring it with you for your visit to Marin Specialty Surgery Center and we will place it in your medical record for reference in the unlikely event you are transferred to the hospital.

If you do not have an Advance Directive and would like more information please contact our office at 415-461-4400. or...

...see the California Office of the Attorney General's Websites:

- http://www.ag.ca.gov/consumers/general/adv_hc_dir.php
- <http://ag.ca.gov/consumers/pdf/AHCDS1.pdf>

...contact the U.S. Living Will Registry

- <http://uslivingwillregistry.com/contact.shtml>
U.S. Living Will Registry
523 Westfield Ave., P.O. Box 2789
Westfield, NJ 07091-2789
- Phone: 1-800-LIV-WILL (1-800-548-9455)
Fax: 1-908-654-1919
Send E-mail To: admin@uslivingwillregistry.com

Patient Rights and Responsibilities

SCA observes and respects a patient's rights and responsibilities without regard to age, race, color, sex, national origin, religion, culture, physical or mental disability, personal values or belief systems.

You have the right to:

- Considerate, respectful and dignified care and respect for personal values, beliefs and preferences.
- Access to treatment without regard to race, ethnicity, national origin, color, creed/religion, sex, age, mental disability, or physical disability. Any treatment determinations based on a person's physical status or diagnosis will be made on the basis of medical evidence and treatment capability.
- Respect of personal privacy.
- Receive care in a safe and secure environment.
- Exercise your rights without being subjected to discrimination or reprisal.
- Know the identity of persons providing care, treatment or services and, upon request, be informed of the credentials of healthcare providers and, if applicable, the lack of malpractice coverage.
- Expect the center to disclose, when applicable, physician financial interests or ownership in the center.
- Receive assistance when requesting a change in primary or specialty physicians or dentists if other qualified physicians or dentists are available.
- Receive information about health status, diagnosis, the expected prognosis and expected outcomes of care, in terms that can be understood, before a treatment or a procedure is performed.
- Receive information about unanticipated outcomes of care.
- Receive information from the physician about any proposed treatment or procedure as needed in order to give or withhold informed consent.
- Participate in decisions about the care, treatment or services planned and to refuse care, treatment or services, in accordance with law and regulation.
- Be informed, or when appropriate, your representative be informed (as allowed under state law) of your rights in advance of furnishing or discontinuing patient care whenever possible.
- Receive information in a manner tailored to your level of understanding, including provision of interpretative assistance or assistive devices.
- Have family be involved in care, treatment, or services decisions to the extent permitted by you or your surrogate decision maker, in accordance with laws and regulations.
- Appropriate assessment and management of pain, information about pain, pain relief measures and participation in pain management decisions.
- Give or withhold informed consent to produce or use recordings, film, or other images for purposes other than care, and to request cessation of production of the recordings, films or other images at any time.
- Be informed of and permit or refuse any human experimentation or other research/educational projects affecting care or treatment.
- Confidentiality of all information pertaining to care and stay in the center, including medical records and, except as required by law, the right to approve or refuse the release of your medical records.
- Access to and/or copies of your medical records within a reasonable time frame and the ability to request amendments to your medical records.
- Obtain information on disclosures of health information within a reasonable time frame.
- Have an advance directive, such as a living will or durable power of attorney for healthcare, and be informed as to the center's policy regarding advance directives/living will. Expect the center to provide

the state's official advance directive form if requested and where applicable.

- Obtain information concerning fees for services rendered and the center's payment policies.
- Be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Expect the center to establish a process for prompt resolution of patients' grievances and to inform each patient whom to contact to file a grievance. Grievances/complaints and suggestions regarding treatment or care that is (or fails to be) furnished may be expressed at any time. Grievances may be lodged with the state agency directly using the contact information provided below.

You are responsible for:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the center.
- Identifying any patient safety concerns.
- Observing prescribed rules of the center during your stay and treatment.
- Providing a responsible adult to transport you home from the center and remain with you for 24 hours if required by your provider.
- Reporting whether you clearly understand the planned course of treatment and what is expected of you and asking questions when you do not understand your care, treatment, or service or what you are expected to do.
- Keeping appointments and, when unable to do so for any reason, notifying the center and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in your condition or any other patient health matters.
- Promptly fulfilling your financial obligations to the center, including charges not covered by insurance.
- Payment to center for copies of the medical records you may request.
- Informing your providers about any living will, medical power of attorney, or other advance directive that could affect your care.

You may contact the following entities to express any concerns, complaints or grievances you may have:

CENTER	JUSTIN DY, RN, BSN, CNOR ADMINISTRATOR (415) 461-4400
STATE AGENCY	ATTN: KATHLEEN J. BILLINGSLEY, RN DEPUTY DIRECTOR CALIFORNIA DEPARTMENT OF PUBLIC HEALTH CENTER FOR HEALTH CARE QUALITY (CHCQ) LICENSING AND CERTIFICATION DIVISION P.O. BOX 997377 MS 3000 SACRAMENTO, CA 95899 COMPLAINTS (800) 236-9747 GENERAL INFORMATION (916) 558-1784
MEDICARE	OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN: www.cms.hhs.gov/center/ombudsman.asp

SCA MISSION: To care for our patients, serve our physicians, and improve healthcare in America



an affiliate of **SCA**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Notice of Privacy Practices

At Surgical Care Affiliates ("SCA"), we understand that medical information about you and your health is personal, and we are committed to protecting that information. This Notice of Privacy Practices describes how we and the medical staff and personnel who provide you with care or services at this facility may use and disclose your PHI to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI ("PHI"), which is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, you can receive any revised Notice of Privacy Practices by accessing our website www.scasurgery.com, contacting the facility where you received services, or by contacting SCA's Privacy Officer at privacyofficer@scasurgery.com.

1. How We May Use and Disclose Your PHI. We may use or disclose your PHI as described in this Section 1. The following are examples of the types of uses and disclosures of your protected healthcare information that SCA is permitted to make without your specific authorization. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our facility.

Treatment: We may use PHI about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other personnel who are involved in your care. We also may disclose PHI about you to individuals outside of SCA who may be involved in your medical care, such as family members or others we use to provide services that are part of your care.

Payment: Your PHI will be used, as needed, to obtain payment of your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a surgery may require that your relevant PHI be disclosed to your health plan.

Healthcare Operations: We may use or disclose your PHI as needed to support our business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other healthcare operations. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel and others to:

- Evaluate the performance of our staff
- Assess the quality of care and outcomes in your case and similar cases
- Learn how to improve our facilities and services
- Determine how to continually improve the quality and effectiveness of the health care we provide.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We will share your PHI with third party "business associates" that may perform various activities (e.g., billing, transcription services) for SCA. Whenever an arrangement between our facility and a business associate involves the use or disclosure of your PHI, we will require the business associate to appropriately safeguard it.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your healthcare will be disclosed. We may use and disclose your PHI in the following instances.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms) and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told of your religious affiliation.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, about your general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your PHI without your authorization in the following situations:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI to the governmental entity or agency authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration ("FDA"): We may disclose your PHI to a person or company required by the FDA to report information such as adverse events and product defects, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance.

Legal Proceedings: We may disclose PHI in response to a court or administrative order. We may also disclose PHI in response to a subpoena, discovery request, or other lawful process, but only if a reasonable effort has been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release PHI for certain law enforcement purposes including, for example, reports required by law, to comply with a court order or warrant, or to report or answer questions about a crime.

Coroners, Funeral Directors and Organ Donation: We may disclose PHI to a coroner, medical examiner or funeral director as necessary to permit them to carry out their duties.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command

authorities (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President of the United States or other officials.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you, and to the Department of Health and Human Services when required to determine our compliance with the requirements of the Federal Privacy Standards.

2. Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights. We have the right to deny your request in certain circumstances. We will inform you if your request is denied.

Right to access your PHI. You may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your healthcare provider and SCA use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. Please contact the facility's Medical Records Department if you have questions about access to your medical record. If you request a copy of the information, we may charge a fee for the costs of retrieving, copying, mailing and any other supplies associated with your request. Your records remain the property of SCA.

Right to request a restriction on the use or disclosure of your PHI. You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Right to request to receive confidential communications from us. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will attempt to accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to the facility's Medical Records Department.

Right to request amendment. If you think that the PHI we have about you is wrong or incomplete, you may ask us to amend the information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact the facility's Medical Records Department if you have a question about amending your medical record.

Right to request an accounting of certain disclosures. You may request a list of our disclosures of your PHI, subject to several exceptions and limitations. For example, this right does not apply to disclosures for purposes other than treatment, payment or healthcare operations, and it excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures.

Right to obtain a paper copy of this notice. You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. To request a copy of this notice, you must make your request in writing to SCA's Privacy Officer (contact information is below).

3. Questions and Complaints

You may file a complaint with us or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer at (205) 545-2713 or privacyofficer@scasurgery.com for further information about the complaint process. This notice was effective on April 14, 2003 and revised on July 1, 2007.



5. Insurance & Billing Information

Phone: 415-461-4400

Fax: 415-461-4484

Insurance and Billing Phone: 415-496-2243

We understand that having a surgical procedure can be a stressful event and with so many considerations to make, questions about the billing and payment for services associated with your procedure are sometimes overlooked or somewhat confusing. The following information will hopefully answer some of these questions for you. Please do not hesitate to call our Business Office should you have any further questions.

Insurance Information

We know that health care insurance can be confusing. Please take a brief moment to review this page to help you understand some key points about your insurance as it relates to your procedure at Marin Specialty Surgery Center.

- A representative from Marin Specialty Surgery Center billing office will contact you prior to the day of your procedure to give you an estimate of your personal portion of the cost of your procedure. This estimate is based on the procedure(s) your physician has scheduled and the type of insurance plan you have. (**Note: You will not receive a call if we do not expect you to have a patient portion or have MEDICARE coverage.**)
- It is important to know that this is only an estimate. Sometimes the surgeon needs to do more or maybe even less during the procedure than what is originally scheduled. These changes may affect your final financial responsibility to Marin Specialty Surgery Center. Once the claim has been processed by your insurance, you may receive a bill for the balance due or a refund if you have overpaid us.
- Payment of co-pays, coinsurance and any deductible amounts that are due are expected upon your check-in to the center. A description of each is as follows:
 1. A **co-pay** is a form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. There may be separate co-payments for different services. Some plans require that a deductible first be met for some specific services before a co-payment applies.
 2. A **deductible** is a fixed dollar amount during the benefit period (usually a year) that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both individual and family deductibles. Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.
 3. **Coinsurance** is the amount due by the patient after the insurance has paid and applied all deductibles and co-pays. This is the amount that is usually described as "Patient Responsibility" or "Member Responsibility" on the Explanation of Benefits. It is usually a percentage of the allowed amount covered by your insurance (i.e. 80/20; 70/30; 90/10). Because we contract with many insurance carriers, we can determine your coinsurance in advance based on the information received by your physician's office at the time of scheduling.

Billing Information

Because there are several healthcare practitioners who are providing a service to you, there will be separate bills generated from each of these providers; therefore, you can plan to expect bills from multiple providers for one procedure at our Surgery Center.

- Our bill is from Marin Specialty Surgery Center, which is the facility fee.
- You will also receive a bill from your physician.
- If pathology is necessary you will also receive a separate bill from the pathologist.

Marin Specialty Surgery Center will bill your procedure to your insurance company for the facility portion, and to a second insurance provider, if you have one. Ultimately, you are responsible for the charges associated with your procedure.

Please call us at the numbers above if you have any questions. Thank you.

- | |
|--|
| 6A. Information <ul style="list-style-type: none"> ▪ Scheduling ▪ Directions ▪ Telephone #s |
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Your Spine Care Appointment is scheduled at the Marin Specialty Surgery Center (MSSC)
If you need to cancel or reschedule your appointment...

- Call your doctor's office:
- Same Day Cancellation prior to 9AM; call MSSC, 415-461-4400 in addition to your doctor's office.

Date of Service:		Notes:
Scheduled Time:		
Please Arrive at:		
Estimated time of Stay:		

Directions to MSSC, 505 Sir Francis Drake Blvd., Greenbrae, CA 94904

From Hwy 101

- Exit Sir Francis Drake Blvd. / San Anselmo heading WEST
- See the Bon Air Shopping Center on the LEFT (SOUTH side of street, 2nd stop light)
- See the Bank of Marin next to the Shopping Center
- MSSC is the building between the Bank of Marin and Frank Howard Allen
 - ❖ look for the large white 505 address numbers on the roof
 - ❖ see the seal fountain and American Flag in front
 - ❖ pass the building,
- Stay in the LEFT hand lane
- Make a U turn at El Portal (3rd stop light) to head EAST in order to turn into the parking lot

From Mt. Tam Spine Care

- Exit the parking lot, turning RIGHT on to Bon Air
- Pass the Marin General Hospital on the RIGHT
- Turn RIGHT on Sir Francis Drake Blvd., heading EAST
- Pass El Portal
- Look for 505, just past Frank Howard Allen, before Bank of Marin and the Shopping Center
- Turn RIGHT, directly into the parking lot

Marin Specialty Surgery Center Telephone #s

- Main Telephone: 461-4400
- Main Fax: 461-4484
- Pre-Procedure RN: 461-4400
- Pre-Procedure Fax: 866-425-0414
- MSSC Billing Office : 496-2243

Common Information and Instructions for Spine Care Procedures

To achieve best results, please prepare for your procedure. Read the instructions and information below. Failure to come prepared and on time may require you to reschedule. Thank you

Notify your Physician or nurse when you are scheduling and on the day of your procedure...

- If you are currently being treated for any infections.
- If you are taking anti-coagulant drugs such as "Coumadin" or "Heparin".
- If there is any chance you are pregnant. X-ray exposure is not recommended during pregnancy.
- If you are a diabetic.

Arrive 30 minutes before your scheduled appointment. You will need to fill out some paperwork, and a pain assessment chart. Most procedures take about 30 min to perform, with an additional 15 min in recovery.

Bring your current insurance card and any other forms requested by your doctor.

Wear loose fitting clothing if possible.

Arrange for a ride home. If You Are Having Sedation, you will not be able to drive yourself. Even if you are not planning on having any sedation, it is still advisable to have someone drive you home. With some procedures you may experience temporary limb weakness or dizziness.

Follow the "567" Rule

5 Days prior to your procedure Anti-Coagulants must be STOPPED

Your doctor may require you to have lab work drawn prior to your injection. Please follow your doctor's instructions carefully. Ask the lab to *fax results to: 866-425-0414 &/or 415-496-2244.*

6 Hours prior to your procedure NOTHING to EAT or Drink, including gum

BLOOD PRESSURE, HEART & SEIZURE medicines should always be taken with a sip of water at their regularly scheduled time, unless otherwise instructed by your physician. It is also OK to take your other regularly scheduled meds (except for those to be stopped) with a sip of water.

7 Days prior to your procedure NO Aspirin or Anti-Inflammatory Drugs

If you are unsure whether your medicine should be restricted, ask your doctor or a pharmacist. Common anti-inflammatory drugs include, "Motrin", "Advil", "Ibuprofen", see ("COMMON MEDS TO STOP SHEET")

General Information for Common Procedures

Fluoroscopy: Fluoroscopy is X-Ray imaging of the body, the image is displayed on a monitor. This insures proper placement of medication. Fluoroscopy is used on most of the procedures.

Epidural Block: This is a block that is performed under fluoroscopy to confirm a specific diagnosis and/or decrease pain and inflammation. A local skin anesthetic is administered. A spinal needle is then placed in the epidural space of the lumbar or cervical spine. An anesthetic and steroid are then injected into the epidural space.

Selective Nerve Root Block: This injection is done to reduce pain and inflammation around a specific nerve root after it exits the spinal canal. Temporary numbness, tingling or motor weakness of affected limb is possible.

Facet Joint Block: These joints are located along each side of the spine, where one vertebrae slightly overlaps the adjacent vertebrae. These joints guide and restrict movement of the spine. An anesthetic and steroid are then injected into the facet joint. Improvements may be noticed immediately. Some significant improvements could be delayed up to 14 days. Possible low back ache for 2-7 days.

Rhizotomy, Discogram, Vertebroplasty, Nucleoplasty, Percutaneous Discectomy, Spinal Implantation: Discuss procedure and expectations with your doctor.

What to Expect After Your Procedure:

- Icing the area of the injection 20-30 minutes at a time, 3 times a day, will reduce local soreness. On the 2nd or 3rd day, you may prefer heat. Use ice or heat with caution, if the skin is still numb.
- After the procedure, avoid excessive exercise, for at least one week, even if you are feeling great.
- If you are currently in physical therapy, resume the routine one week following your injection.
- Be sure to report back to your treating physician as recommended.
- With any steroid injection; headache, breast tenderness, insomnia, nausea, or fluid retention are possible side effects. (see sheet on "CORTICOSTEROID NOTES")
- Following a Block Procedure, you may experience (depending on the level of your injection): Lower back, sacral, leg, neck or arm symptoms. They might include; temporary numbness, aching, an increase in pain for 1-3 days.

CORTICOSTEROID NOTES

Corticosteroids are produced naturally by your body and are necessary for good health. The function of corticosteroids as a supplemental anti-inflammatory medication is well known. Physicians prescribe the medication for a variety of conditions. Commonly, they are prescribed, to supplement the body's natural supply. They are also frequently used as part of a treatment for diseases such as allergies, skin problems, asthma and arthritis. Corticosteroids can also be used for any other conditions your doctor determines appropriate.

The anti-inflammatory properties are useful in providing relief to a variety of inflamed areas on and within the body. When used directly on the skin they may lessen swelling, redness and itching. For patients with inflammation in the nerves and /or joints within the spine, a direct injection of the medication into the area may provide a significant reduction in the degree or duration of the inflammation.

You may have concerns about steroid medications because of previous ideas. Like all medications if corticosteroids are abused or used to often they may be harmful. If used correctly they may be very helpful.

After your procedure, if you experience any side effects of the corticosteroids you should report all symptoms to your doctor. Many effects usually do not require medical attention but are useful in monitoring typical effects. You should check with your doctor immediately if you notice dizziness, fainting, fever, chills and/or shortness of breath.

Common side effects may include:

- Decreased or blurred vision
- Frequent urination
- Increased thirst
- Diabetics may notice a change in their blood sugar levels. It may be higher than normal.

Rare side effects may include

- Restlessness
- Insomnia
- Confusion
- Excitement
- False sense of well being Allergic skin reactions

You should tell your doctor, nurse and pharmacist if you have any of the following

- Medication allergies
- Pregnant or breast-feeding
- Prescription or nonprescription medications
- Active or recent infections
- Open wounds, sores, recent surgeries
- Other Medical problems
- Hiccups Mood swings
- Mental depression
- Redness Swelling
- Avascular necrosis (Decreased blood flow to joint)

Remember the 567 Rule

Prior to injection...
No anticoagulants for 5 days
Nothing to eat or drink for 6 hours
No NSAIDs (non steroidal) for 7 days



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6D. Medication Notes

This is a partial list and is updated as needed.
If you are unsure if your medicine should be stopped, call your doctor.

Common Medications to be stopped prior to your Spine Care Procedure

MEDS to be stopped 7 days before

ADVIL
AGGRENOL
AGRYLIN
ALEVE
ALKA-SELTZER
ANACIN
ANCASAL
ASPERGUM
ASPIRIN
BAYER
BUFFERIN
CLINORIL
DAMASON-P
DARVON COMPOUND
DARVON WITH ASPIRIN
DAYPRO
DOLOBID
EASPRIN
ECOTRIN
EMPIRIN
ETODOLAC
EXCEDRIN
FELDENE
FIORINAL
GINKGO BILOBA
IBUPROFEN

MEDS to be stopped 7 days before

INDOCIN
INDOCID
KETOPROFEN
LODINE
MEASURIN
MECLOMEN
MEDIPREN
MIDOL
MOBIC
MOTRIN
NALFON
NAMEBUTONE
NAPROSYN
NUPRIN
ORUDIS
PERCODAN
PIROXACAM
RELAFEN
RUFEN
SALSALATE
SOMA COMPOUND
TANDEARIL
TICLID
TOLECTIN
TORADOL

MEDS to be stopped 7 days before

TRILISATE
VOLTAREN
DICLOFENAC
ZORPRIN

ANTICOAGULANTS Stop for 5 days before

ARIXTRA LOVENOX
COUMADIN PLAVIX
ENOXAPRIN WARFARIN
FRAGMIN HEPARIN

OK MEDS TO BE TAKEN (unless noted)

BLOOD PRESSURE medications
HEART medications
SEIZURE medications
REGULARLY SCHEDULED medications

OK PAIN MEDICATIONS:

CELEBREX	NORCO	TRAMADOL
DARVOCEP	OXYCODONE	TYLENOL
ENDOCET	OXYCONTIN	ULTRAM
LORCET	PERCOCET	ULTRACET
LORATAB	ROXICONDE	VICODIN
NEURONTIN	SOMA	



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PRE OPERATIVE QUESTIONNAIRE Page 2
GENERAL HEALTH

7. Pre-op Questionnaire pg 2

Patient Name: _____

Sticker on arrival

Do you have, or have you ever had any of the following. Please use space on pg 1 to explain.

Nervous System	YES	NO
Seizures &/or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Black out spells	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis or weakness	<input type="checkbox"/>	<input type="checkbox"/>
Equilibrium problems	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Other Neurological problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart & Blood Vessels	YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Do you take diuretics or "water pills"	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur / mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Chest / pain	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beats	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis / Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Automatic Internal defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Personal	YES	NO
Do you drink Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
# glasses/day _____ # glasses/wk _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
Clean and Sober for _____	<input type="checkbox"/>	<input type="checkbox"/>
In rehab presently	<input type="checkbox"/>	<input type="checkbox"/>
Anything removable in your mouth	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contacts	<input type="checkbox"/>	<input type="checkbox"/>
Women: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Last Menstrual Period _____	<input type="checkbox"/>	<input type="checkbox"/>
Body Piercings remove all metal jewelry before surgery	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing (circle) Right, Left	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aide (circle) Right, Left	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory System	YES	NO
History of smoking? # yrs _____ when quit _____	<input type="checkbox"/>	<input type="checkbox"/>
Packs / day _____ cig / day _____	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine? Other? _____	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema / COPD	<input type="checkbox"/>	<input type="checkbox"/>
Other lung problems	<input type="checkbox"/>	<input type="checkbox"/>
Gastro-Intestinal / Urinary / Abdomen	Yes	NO
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Gastric Reflux Disease / "Heart Burn"	<input type="checkbox"/>	<input type="checkbox"/>
Special bowel/bladder needs	<input type="checkbox"/>	<input type="checkbox"/>
Other abdominal problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Last Blood Glucose date/time _____ / _____	<input type="checkbox"/>	<input type="checkbox"/>
Benign Prostatic Hypertrophy	<input type="checkbox"/>	<input type="checkbox"/>
Skeletal / Other	YES	NO
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
History of Back or Neck surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Backaches	<input type="checkbox"/>	<input type="checkbox"/>
Implanted Hardware	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Total joint surgery	<input type="checkbox"/>	<input type="checkbox"/>
Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone drugs taken w/in the past 2 yrs.	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics for dental procedures	<input type="checkbox"/>	<input type="checkbox"/>
Recent Cough, Cold, Flu, infections	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems, bruises, rashes... describe	<input type="checkbox"/>	<input type="checkbox"/>
Current outbreak of acne, herpes...describe	<input type="checkbox"/>	<input type="checkbox"/>
History of antibiotic Resistant infections?	<input type="checkbox"/>	<input type="checkbox"/>
History of cancer	<input type="checkbox"/>	<input type="checkbox"/>
Latex: Sensitivity or Allergy	<input type="checkbox"/>	<input type="checkbox"/>



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

You may refuse to sign this acknowledgement

SCA will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information.

The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution.

By signing below, I acknowledge that I have received a copy of this facility's Notice of Privacy Practices.

Please Print Name

Signature

Date

YOU ARE ENTITLED TO A COPY OF THIS ACKNOWLEDGEMENT AFTER YOU SIGN IT

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Include completed acknowledgement in the patient's Medical Record



As of January 1, 2005, California state law requires hospital emergency departments and all ambulatory surgery centers to report the causes of injury to our patients (Section 97227 of the California Code of Regulations). The purpose of this requirement is to help governmental agencies to create strategies to minimize injuries and the costs associated with those injuries. The cause of your injury will be reported to the state as a standardized number code.

The information you complete below will be maintained in the strictest confidence. Your name will not be reported to the state with this information and your answers will not become a part of your medical record.

1. Was the condition you are being treated for today caused by an accident or other external cause (such as repetitive stress)? Yes No
If yes, please answer the following questions:

Date of injury: _____

How did the accident/injury happen? _____

Where did the accident/injury happen? _____

2. Have you been treated for your condition at an emergency room, hospital, or surgery center before today? (Your doctor's office does not count.) Yes No

3. *As of January 1, 2005, the State of California, Office of Statewide Health Planning and Development (OSHPD) mandate that Ambulatory Surgery Centers collect individual encounter data, including race and ethnicity. If you have any questions, please contact the Patient Data Section of OSHPD at 916-324-6147. Additional information is available on the internet at www.oshpd.cs.gov/mircal.

Please mark one (1) box per section below

***Race**

- American Indian
- Asian
- Black/African American
- Other
- Hawaiian/Pacific Islander
- White

***Ethnicity**

- Hispanic/Latino
- Unknown
- Non Hispanic/Non Latino

***Primary Language Spoken**

- | | | |
|------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Hindu | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Hmong | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Italian | <input type="checkbox"/> Serbian |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Croatian | <input type="checkbox"/> Korean | <input type="checkbox"/> Thai |
| <input type="checkbox"/> French | <input type="checkbox"/> Laotian | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> German | <input type="checkbox"/> Miao | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Mon-Khmer | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Gujarathi | <input type="checkbox"/> Navajo | <input type="checkbox"/> Yiddish |
| <input type="checkbox"/> Hebrew | <input type="checkbox"/> Persian | <input type="checkbox"/> Unknown |