1931 Oak Tree Road, Suite 100
Edison, NJ 08820
732-603-8603

# Welcome to Oak Tree Surgery Center

Kindly, complete this packet and bring it with you on the day of your procedure. If you forget, you will have to fill it out on the day of your procedure, and you will delay your admission process.

You will be called by an Oak Tree Surgery Center Registered Nurse approximately 2 days prior to your procedure date to review your medical history and go over your medications. Please make sure you have a list of your medications and the dose available to review with the nurse.
If you do not receive a call from us, please call us at 732-603-8603.

## ON THE DAY OF YOUR PROCEDURE:

** If you are experiencing a fever greater than 100.0°F, cough, shortness of breath, loss of smell/taste, shaking chills, muscle pain, sore throat, or any other respiratory symptoms, please notify the staff at Oak Tree Surgery Center immediately. **

Your appointment time will be strictly enforced to maintain social distancing. There will be NO "first come first serve." If you arrive early, you must wait until your scheduled time. NO EXCEPTIONS!

- Plan for yourself and your driver to arrive with a clean face covering, which must be worn at all times.
- Upon arrival at our parking lot, please call the receptionist at 732-603-8603 and inform them of your arrival *and wait with your driver in the car for further instructions*.
- Your driver must remain in the car / outside of the building. Communication between the driver and staff will be via telephone only (including translation). Our staff will contact your driver once your procedure is completed. At pick up, your driver will sign our discharge instructions form.
- Use of hand sanitizer and appropriate PPE will be available to you throughout your stay.
- Social distancing will be adhered to as much as possible.
- Please have your photo ID, insurance card and, if applicable, a method of payment ready.

For billing questions PRIOR to your procedure please contact the billing office at 855-457-2561
For billing questions AFTER your procedure please contact the billing office at 855-457-2560
For Anesthesia billing questions please contact Oak Tree Anesthesia Assoc. 800-242-5080

**OAK TREE SURGERY CENTER**
1931 Oak Tree Rd. Edison, NJ 08820
Tel: (732) 603-8603 Fax: (732) 603-8634

# ADULT - PATIENT MEDICAL HISTORY QUESTIONNAIRE

| Name: | Date of Birth: | Age: | Height: | Weight: |
|---|---|---|---|---|
| | | | | |

Allergy / Reactions: *PLEASE LIST ON "ALLERGY / MEDICATION RECONCILIATION FORM"*

Past operations you have had and their dates: _____

_____

Past hospitalizations and diagnosis: _____

_____

1. Do you have a first degree relative (mother/father, brother/sister, child) with colorectal, endometrial, or ovarian cancer before age 50? ☐ YES ☐ NO If YES, describe_____
2. Have you had colorectal cancer, endometrial, or ovarian cancer before age 50 or any of these cancers more than once? ☐ YES ☐ NO If YES, describe _____
3. Do you have 3 or more relatives with colorectal, endometrial, or ovarian cancer (any combination)? ☐ YES ☐ NO If YES, describe_____

☐ YES ☐ NO Have you or anyone in your family experienced malignant hyperthermia / complications with anesthesia? If YES, please describe: _____

☐ YES ☐ NO Recent cold or flu? If YES, when? _____

☐ YES ☐ NO Do you smoke? ☐ cigarette ☐ cigar If YES, how long? _____ How many packs a day? _____

☐ YES ☐ NO Do you vape? If YES, how long? _____ How many times a day? _____

☐ YES ☐ NO Do you take recreational drugs? – *important as it may impact your anesthesia care*
Please list (e.g. marijuana, cocaine): _____ How often? _____

☐ YES ☐ NO Do you drink alcohol? If YES, how often? _____ How much? _____

☐ YES ☐ NO Do you have loose teeth, caps, partial bridge, or dentures?

☐ YES ☐ NO Do you have lung disease, asthma, bronchitis, or emphysema?
Last time you were wheezing? _____

☐ YES ☐ NO Do you have sleep apnea? If YES, do you use a CPAP machine? ☐ YES ☐ NO

☐ YES ☐ NO Do you experience shortness of breath upon climbing up a flight of stairs or less?

☐ YES ☐ NO Have you had a heart attack? If YES, when? _____
Have you seen your cardiologist in the last 3 months? ☐ YES ☐ NO

☐ YES ☐ NO Do you have any cardiac stents? If YES, when?_____ How many? _____
Have you seen your cardiologist in the last 3 months? ☐ YES ☐ NO

☐ YES ☐ NO Do you have congestive heart failure?
If YES, have you seen your cardiologist in the last 3 months? ☐ YES ☐ NO

☐ YES ☐ NO Do you have angina or chest pain? If YES, how often? _____
Have you seen your cardiologist in the last 3 months? ☐ YES ☐ NO

☐ YES ☐ NO Have you had a past stress test or cardiac catheterization?
If YES, when and what were the results? _____

☐ YES ☐ NO Do you have high blood pressure? If YES, are you taking medication? ☐ YES ☐ NO

☐ YES ☐ NO Do you have high cholesterol? If YES, are you taking medication? ☐ YES ☐ NO

☐ YES ☐ NO Have you ever had a stroke? If YES, when? _____

☐ YES ☐ NO Do you have anemia, sickle cell, or other blood diseases?
If YES, describe: _____

☐ YES ☐ NO Do you have diabetes? If YES, describe: _____

☐ YES ☐ NO Do you have any thyroid problems? If YES, describe: _____

☐ YES ☐ NO Do you have any liver problems? If YES, describe: _____

☐ YES ☐ NO Do you have epilepsy or seizures? If YES, describe: _____

☐ YES ☐ NO Do you have headaches, migraines, back or neck pain? If YES, describe: _____
_____

☐ YES ☐ NO Do you have any weakness or numbness in a limb? If YES, describe: _____

☐ YES ☐ NO Do you have any excessive bleeding or bruising? (e.g. nosebleed) If YES, describe: _____
_____

☐ YES ☐ NO Do you have a hiatal hernia?

☐ YES ☐ NO Do you have arthritis or any rheumatological disease?

☐ YES ☐ NO Do you have any other significant illness(es)? If YES, describe: _____
_____

☐ YES ☐ NO FEMALE PATIENTS: Could you be pregnant?

☐ YES ☐ NO Has your Medical Doctor (family doctor / primary care doctor) cleared you for your procedure?
Medical Doctor name: _____

☐ YES ☐ NO If you have heart disease, has your cardiologist cleared you for your procedure?
Cardiologist name: _____

**I understand that I am not to eat, or drink as instructed prior to the day of my procedure unless instructed otherwise by the surgery center staff. I also understand that I must have a responsible adult to accompany me home (NO taxi service will be permitted) after discharge from Oak Tree Surgery Center.**

_____ _____
Patient Signature Date

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## STATEMENT OF LIMITATION REGARDING ADVANCED DIRECTIVE

In the state of New Jersey, all patients have the right to participate in their own healthcare decisions and to make Advanced Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Oak Tree Surgery Center respects and upholds those rights. However, unlike in an acute care hospital setting, Oak Tree Surgery Center does not routinely perform "high risk" procedures. While no procedure is without risk, most procedures performed at this center are considered to be at minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions regarding its risks, your expected recovery, and care after your procedure. Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. CMS (CRF 416.50 Conditions from Coverage) permits us to decline to implement certain elements of your Advanced Directive, based on our conscience and commitment to patient care.

***It is the policy of Oak Tree Surgery Center that if an adverse event occurs during your procedure or treatment, the medical surgical team will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. We will share your Advanced Directive with the caregivers at the acute care hospital where you are transferred. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive or health care power of attorney. If you do not agree with our facility policy, we will assist you to reschedule your procedure in a facility more suited to meet your healthcare needs.***

Do you have an Advanced Directive? ☐ YES ☐ NO

If "YES"
- ☐ I have an Advanced Directive and it was provided to the Facility.
- ☐ I have an Advanced Directive and it was **NOT** provided to the Facility.

If "YES"
- ☐ I agree to proceed with my scheduled procedure and authorize the suspension of my Do Not Resuscitate / Advanced Directive while at the surgery center. **
- ☐ I **DO NOT** agree to proceed with my scheduled procedure and authorize the suspension of my Do Not Resuscitate / Advanced Directive while at the surgery center.

If "NO"
- ☐ I would like information regarding creating an Advanced Directive.
- ☐ I do not want information regarding creating an Advanced Directive.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____ _____
Physician Signature ** Date

** Physician signature required when patient is authorizing the suspension of the Do Not Resuscitate / Advanced Directive

## Oak Tree Anesthesia Associates, LLC & Anesthesia Dynamics, LLC

### Providing Professional Anesthesia Services for patients of Oak Tree Surgery Center

**Assignment of Benefits**: In consideration of the services provided to me, I hereby assign and transfer to Oak Tree Anesthesia Associates, LLC **(OTAA)** and Anesthesia Dynamics, LLC **(AD)** all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of Practice charges for this admission or other amounts as may be provided by an agreement between OTAA/AD and my insurance company. I authorize and direct the insurance company to pay all such benefits to OTAA/AD. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and OTAA/AD.

**Authorization to Release Claims Information**: I hereby authorize OTAA/AD its employees, contractors, and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my, the patient's, medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare) or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize OTAA/AD its employees and agents to act on my behalf in completing claims including any appeal process.

**Precertification & Financial Responsibility**: I understand that my insurer may require compliance with utilization review (UR) program to ensure that plan benefits are justified. I understand that it is the insurer's UR program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the UR program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that OTAA is willing to provide professional anesthesia services as requested by my attending physician. I also understand that I may be financially responsible for all related charges incurred as a result of this admission should the UR review program refuse to certify that the admission or a specific service was appropriate or should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company, UR program and personal physician without delay and in advance of my admission.

**Authorized Representation:** I do hereby name OTAA/AD to act as my authorized representative in requesting a complaint, an appeal, and documents from my health insurance provider regarding services rendered by OTAA/AD. I understand and agree that 1) this authorization is voluntary: 2) my health information may contain information created by other persons or entities including healthcare providers and may contain medical, pharmacy, dental, vision, mental, health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care information; 3) I may not be denied treatment, payment for healthcare services, or enrollment or eligibility for healthcare benefits if I do not sign this form; 4) this authorization will expire one year from the date I sign this form. I may revoke this authorization at any time by notifying OTAA/AD and/or health insurance provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

**Signature of Patient/Authorized Guardian Signature** **Date**

## PATIENT NOTICE REGARDING ANESTHESIA SERVICES

Anesthesia services are provided at Oak Tree Surgery Center by OTAA/AD. OTAA/AD contracts and employs certified registered nurse anesthetists as part of the anesthesia care team.

Anesthesia services will be billed separately from the services of Oak Tree Surgery Center.

For billing questions or concerns, please call: 732-924-3488 or 1-800-242-5080

In the event that OTAA/AD is not a participating provider with your insurance plan, OTAA/AD will work with your insurance carrier through various appeal efforts in order to minimize any penalties or costs that your insurance says that you owe. We are often able to negotiate with your insurer to reduce your out-of-pocket expenses that may result from OTAA/AD's out-of-network status, but we cannot guarantee a result. You will also be required to pay the deductible and/or co-pay amounts determined by your policy/plan.