The Kissimmee FL Endoscopy ASC, LLC

715 Oak Commons Blvd, Kissimmee, FL 34741
407-931-2816 Phone 407-931-3485 Fax

PLEASE COMPLETELY FILL OUT THE ATTACHED AND BRING THEM WITH YOU TO THE KISSIMMEE FL ENDOSCOPY ASC, LLC ON THE DAY OF YOUR SCHEDULED PROCEDURE.
THANK YOU

Instructions for patients having outpatient procedures at The Kissimmee FL Endoscopy ASC, LLC:

The Kissimmee FL Endoscopy ASC, LLC is located at 715 Oak Commons Blvd, across the street from the Doctor's Office. Normal business operations for this building are Monday thru Friday, closed Saturdays and Sundays.

Our goal is to make your visit to our facility a smooth, convenient, and time efficient process, so the facility finds it necessary to inform patients of special building conditions.

1. The surgery scheduler at the doctor's office will give the patient paperwork to be completed ***prior*** to arrival for their procedure at the surgery center. Please remember to bring the forms completed and signed.

2. Building entrances open at 0700 AM.

3. There is a restroom located in the lobby for your convenience.

4. Patients having a procedure are ***not allowed to eat or drink*** as instructed in their instructions.

5. Please be advised that you may be at The Kissimmee FL Endoscopy ASC, LLC for at least 2-3 hours. The waiting area can be cold at times, so please bring a sweater or jacket for your comfort.

6. Due to limited seating, we kindly request that each patient be accompanied by only one person, a responsible adult, ***who will remain on premises during the patient's entire visit***.

7. Smoking is prohibited.

8. After the procedure patients will be escorted out through the Exit closest to the parking lot.

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Favor de completar y traer con usted al Kissimmee FL Endoscopy ACS, LLC el dia de su procedimiento. Gracias.

Instruccions para pacientes que van a tener procedimiento en el Kissimmee FL Endoscopy ASC, LLC:

El Kissimmee FL Endoscopy ASC, LLC esta localizado en el 715 Oak Commons Blvd (al frente de la oficina de los doctores.) Los dias laborables son de Lunes a Viernes, cerrado Sabados Y Domingos.

Nuestra meta es que al visitar nuestra facilidad usted tenga un servicio agradable, conveninte y eficiente, y que se le brinde toda la informacion necesaria.

1. La cita se le hara en la oficina del medico y alli se le entregara todos los papeles, que deben ser completados y firmados y traer los el dia de su estudio.

2. El Centro de Endoscopia habre a las 7:00 am

3. El bano esta localizado en el lobby.

4. Los pacientes que tienen procedimientos ***no pueden comer ni beber*** nada segun las instrucciones dadas.

5. Favor de tener presente que el paciente permanecera en el Kissimmee FL Endoscopy ASC, LLC al menos de 2-3 horas. Favor de traer un abrigo, ya que el area de espera siempre esta frio.

6. Debido al espacio limitado se le pide a cada paciente que venga acompanado de una sola persona adulta, que ***debera permanecer en la clinica en todo momento hasta que el paciente le permitan irse a su casa.***

7. FUMAR ESTA PROHIBIDO.

8. Despues del procedimiento el paciente sera escortado por la puerta de salida mas cerca al estacionamiento.

HOME MEDICATION LIST - (Lista de Medicamentos)

Please fill form out as completely as possible.
(Favor completar este formulario.)

Medication Name (Nombre del Medicamento)	**Dosage** (Dosis)	**Route** (Indicacion)	**Frequency** (Frecuencia)	**Last Date Taken** (Ultima vez que la tomo)	**Medication taken for what reason** (Razon porque toma este medicamento)

Allergies (Alergias)	**Reaction to medication** (Reaccion algun medicamento)

Patient Rights and Notification of Physician Ownership

Label for Medical Records

Amsurg Corporation
The Kissimmee FL Endoscopy ASC, LLC
715 Oak Commons Blvd.
Kissimmee, FL 34741
407-931-2816
Fax: 407-931-3485

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISION REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE PRIOR TO THE PROCEDURE/SURGERY.

Patient's Rights:

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
A patient has the right to a prompt and reasonable response to questions and requests.
A patient has the right to know who is providing medical services and who is responsible for his or her care.
A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
A patient has the right to know what rules and regulations apply to his or her conduct.
A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
A patient has the right to refuse any treatment, except as otherwise provided by law.
A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

Patient Responsibilities:

The patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
The patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
The patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
A patient is responsible for following the treatment plan recommended by the health care provider.
A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
A patient is responsible for his or her actions should he or she refuse treatment or does not follow the health care provider's instructions.
A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

If you need an interpreter:

If you need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Rights and Respect for Property and Person:

The patient has the right to:
Exercise his or her rights without being subjected to discrimination or reprisal.
Voice a grievance regarding treatment or care that is, or fails to be furnished.
Be fully informed about a treatment or procedure and the expected outcome before it is performed.
Confidentiality of personal medical information.

Privacy and Safety

The patient has the right to:

Personal privacy.
Receive care in a safe setting.
Be free from all forms of abuse or harassment.

Advance Directives:

You have the right to information regarding advance directives, this facility's policy on advance directives, and information regarding state regulations concerning advance directives. Applicable state forms are available from the center and will be provided upon request.

When a person becomes unable to make decisions due to a physical or mental change or condition, they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death. The state rules that address this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code and Florida statute Title XLIV, Chapter 765.

Kissimmee Endoscopy Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

http://www.floridahealthfinder.gov/reports-guides/advance-directives.shtml
1-888-419-3465

Complaints/Grievances:

If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and/or agencies you may contact:

Charmaine Ephriam
Center Director
715 Oak Commons Blvd., Kissimmee, FL 34741
407-931-2816

You may contact the state to report a complaint:

Florida Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C-75, Tallahassee, Florida 32399-3275
Phone (850) 245-4339 or TF 1-888-419-3456
http://www.doh.state.fl.us/mqa/enforcement/enforce_home.html

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman at www.medicare.gov/Ombudsman/resources.asp

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General: http://oig.hhs.gov

This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:

AAAHC
5250 Old Orchard Road, Suite 200, Skokie, IL 60077
847-853-6060 or email: info@aaahc.org

Physician Financial Interest and Ownership:

The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

The following physicians have a financial interest in this center

M. Siraj Ul Islam, MD
Syed Khalid Lateef, MD FACG
Jaime M. River, MD

X _____
Signature of Patient or Patient Legal Representative

Date _____

PLEASE BRING THIS FORM WITH YOU
ON THE DAY OF YOUR PROCEDURE

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ANESTHESIA QUESTIONNAIRE - ADULTS

Please answer each question prior to your procedure. This will assist the Anesthesia Department in making your pre-anesthesia evaluation.

1. Please list any major illnesses you have had in your life. _____
2. Please list any medication that you take and their doses. _____

CHECK YES OR NO	YES	NO
3. Have you taken prednisone, steroids, or ACTH in the past six months?	☐	☐
4. Are you allergic to any medications: If yes, what? _____ What happens? _____	☐	☐
5. Have you ever had high or low blood pressure?	☐	☐
6. Have you ever had trouble with your heart?	☐	☐
7. Have you ever had a heart attack? If yes, when? _____	☐	☐
8. Do you have angina chest pains? If yes, how often? _____	☐	☐
9. Do you have any trouble with your breathing or lungs? (circle) Asthma Wheezing Emphysema Cough up anything	☐	☐
10. Do you smoke? If yes, how much? _____	☐	☐
11. Have you had a cold or flu in the past two weeks?	☐	☐
12. Does anyone in the family have a cold or flu?	☐	☐
13. Do you have any problems with your breathing while lying flat?	☐	☐
14. Have you ever had a stroke? If yes, when? _____	☐	☐
15. Have you ever had dizziness, fainting spells, seizures, or epilepsy?	☐	☐
16. Do you have any part of your body that is numb or weak?	☐	☐
17. Have you ever had any problems with your liver or kidneys?	☐	☐
18. Have you ever had hepatitis or yellow jaundice? If yes, when? _____	☐	☐
19. Do you have problems with swallowing, heartburn, indigestion, hiatal hernia, or vomiting?	☐	☐
20. Do you have diabetes? If yes, how long? _____	☐	☐
21. Do you have arthritis? If yes, where? _____	☐	☐
22. Have you ever had problems with bleeding or easy bruising?	☐	☐
23. Have you ever had a transfusion? If yes, when? _____	☐	☐
24. Do you wear contact lenses? If yes, please remove before surgery.	☐	☐
25. Do you have (circle) dentures caps bridges loose teeth?	☐	☐
26. Please list any operations you have had and their dates _____		
27. Have you ever had any problems with general anesthetic? If yes, what? _____	☐	☐
28. Have you ever had any problems with spinal anesthetic?	☐	☐
29. Have any relatives had any problems with anesthetics (high fevers, breathing troubles, etc.)?	☐	☐
30. How many drinks or beers do you have in an average day? _____ Week? _____	☐	☐
31. Is there any chance you are pregnant?	☐	☐
32. Date of your last menstrual period _____		
33. Height _____ Weight _____		
34. Do you have any questions?	☐	☐

Patient signature X _____ Date _____

CUESTIONARIO PARA ANESTESIA – ADULTOS

(ANESTHESIA QUESTIONNAIRE – ADULTS)

Por favor responda a cada pregunta antes de su operación. Esto ayudará al Departamento de Anestesia a realizar su evaluación pre-anestesia.

1. Por favor mencione todas las enfermedades serias que haya tenido en su vida. _____

_____

_____

2. Mencione los medicamentos que toma y sus dosis. _____

_____

_____

CHEQUEE SI O NO	SI	NO
3. Ha tornado prednisona, esteroides, o ACTH en los últimos seis meses?	❒	❒
4. Es alérgico(a) a alguna medicina? _____ A cuál? _____ Cómo reacciona a la(s) misma(s)? _____	❒	❒
5. Ha tenido alguna vaz la presión arterial alta o baja?	❒	❒
6. Ha tenido problemás cardiacos?	❒	❒
7. Ha sufrido un ataque al corazón alguna vez? _____ Cuando? _____	❒	❒
8. Padece de dolores anginosos? _____ Cuán frecuentes? _____	❒	❒
9. Padece de problemas respiratorios o pulmonares?	❒	❒
(circule el área) Asma Ruido al respirar Enfisema Tos con esputos		
10. Fuma? _____ Cuántos cigarrillos/paquetes? _____ Por cuánto tiempo? _____	❒	❒
11. Ha tenido usted catarro o el flú en las últimas dos semanas?	❒	❒
12. Hay alguien en su familia con catarro o el flú?	❒	❒
13. Tiene usted problemas al respirar cuando esta, acostado(a) sobre su espalda?	❒	❒
14. Ha sufrido una embolia alguna vez? _____ Cuándo? _____	❒	❒
15. Ha tenido alguna vez *(circule el área)* mareos, desmayos, convulsiones, ataques epilépticos?	❒	❒
16. Hay alguna parte de su cuerpo que esté insensible o débil?	❒	❒
17. Ha tenido alguna vez problemas con su higado o riñones?	❒	❒
18. Ha tenido alguna vez hepatitis, ictericia? _____ Cuando? _____	❒	❒
19. Tiene usted problemas al tragar, *(circule el área)* acidez, indigestion, hernia hiatal o vómitos?	❒	❒
20. Padece de diabetes? _____ Desde cuándo? _____	❒	❒
21. Padece de artritis? _____ Donde? _____	❒	❒
22. Ha tenido alguna vez problemas de sangramiento o facilidad para magulladuras?	❒	❒
23. Ha recibido alguna vez una transfusión de sangre? _____ Cuándo? _____	❒	❒
24. Usa usted lentes de contacto? Si es así, por favor quíteselos antes de la operación	❒	❒
25. Tiene usted *(circule de área)* dentadura postiza coronas puentes dientes flojos	❒	❒
26. Por favor detalle todas las operaciones a las que se ha sometido y sus fechas _____	❒	❒
27. Ha tenido problemas alguna vez con anestesia general? _____ Que tipo de problemas? _____	❒	❒
28. Ha tenido problemas con anestesia requídea?	❒	❒
29. Ha tenido algún familiar problemas con anestesias (fiebre alta, problemas respiratorios, etc.)?	❒	❒
30. Cuántos tragos o cervezas toma usted por día? _____ por semana? _____	❒	❒
31. Hay alguna posibilidad de que usted esté embarazada?	❒	❒
32. Fecha de su última menstruación? _____		
33. Estatura _____ Peso _____		
34. Tiene usted alguna otra pregunta?	❒	❒