CLEAVER MEDICAL GROUP
SURGERY CENTER

Table of Contents

I have read and agreed to the following documents. All my questions and concerns have been answered by my provider and medical staff.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Miranda Reed, DO
Colin Kress, DO

CLEAVER MEDICAL GROUP
SURGERY CENTER

Cleaver Medical Group Surgery Center: (770) 872-6179
(Tuesday & Wednesday: 8:00 AM – 5:00 PM)
Cleaver Medical Group Main Office: (770) 800-3455
(Monday - Friday: 8:00 AM – 5:00 PM)
After Hours On-Call Physician: (762) 366-0800

For surgeries scheduled at Cleaver Medical Group Surgery Center:

Our billing department will be contacting you and will provide you with an **ESTIMATED** cost analysis for PHYSICIAN AND FACILITY fees. Until your claim is processed, an exact patient financial liability is not known. Therefore, the cost analysis our office provides is only an **ESTIMATE**. Patients will be financially responsible for any deductible, co-insurance and/or co-pay amounts assessed by the insurance company regardless of the estimated cost provided prior to surgery.

Anesthesia, imaging, pre-op labs, and all lab fees are not included in estimates provided by our office and will be billed separately by the facility providing the service. **Any questions regarding bills for these services, should be directed to the facility providing the service.**

Depending on the global period for the surgical procedures performed, post-operative visits may NOT be included in surgical fees and the patient will be responsible for any deductible, co-insurance and/or co-pay amounts assessed by the insurance company.

CLEAVER MEDICAL GROUP SURGERY CENTER INSTRUCTIONS

PATIENT RIGHTS

The patient has the right to:

1. become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may have a family member or representative of his/her choice be involved in his/her care.
2. exercise these rights without regard to race, sex, cultural, educational, or religious background or the source of payment for care.
3. be treated with respect, consideration, and dignity in a safe environment free from all forms of abuse or harassment.
4. remain free from seclusion or restraints of any form that are not medically necessary.
5. coordinate his/her care with physicians and healthcare providers and be provided, to the degree known, complete information concerning their diagnosis, evaluation, prognosis and any proposed treatment or procedures as needed to give informed consent or to refuse treatment. This information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment, non-treatment and the risks involved.
6. full consideration of patient privacy concerning consultation, examination, treatment, and surgery.
7. confidential treatment of all communications, disclosures and records pertaining to patient care; patients will be given the opportunity to approve or refuse their release except when release is required by law. Patient will have access to information in the medical record within reasonable time frame (48 hours).
8. leave the facility even against medical advice.
9. be informed about procedures for expressing suggestions, complaints and grievances including those required by state and federal regulations.
10. be informed by physician or designee to the continuing healthcare requirements after discharge.
11. examine and receive an explanation of the bill regardless of source of payment.
12. have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
13. interpretive services if needed.
14. be informed regarding patient conduct and responsibilities, services available at the surgery center, provisions for after-hours and emergency care, fees for services, payment policies, right to refuse participation in experimental research, charity and indigent care policy, charges for services not covered by third-party payors, and credentials of health care professionals.

PATIENT RESPONSIBILITIES

The patient has the responsibility to:

1. provide complete and accurate information concerning present complaints, past illnesses, hospitalizations, other health issues, all medications.
2. make it known whether the planned surgical procedure/treatment risks, benefits and alternative treatments have been explained and understood.
3. follow the treatment plan established by the physician, including instructions by nurses and other health care professionals, given by the physician.
4. keep appointments or notify the facility in advance if unable to do so.
5. accept full responsibility for deciding to refuse treatment and/or not follow directions.
6. fulfill the financial obligations of his/her care as promptly as possible.
7. be respectful of all the health care providers and staff, as well as other patients in the facility and follow facility policies and procedures.
8. notify the staff if they have any safety concerns or feel their privacy is being violated.
9. provide a responsible adult to transport him/her from the surgery center and remain with him/her for 24 hours, if required by his/her provider.
10. inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

PATIENT COMPLAINTS

Patients have the right to register a complaint, in writing, to the Administrator of Cleaver Medical Group Surgery Center. Please submit complaint to:

ATTN: Ashley Dorsey
Cleaver Medical Group Surgery Center
105 Professional Park Drive Suite 200
Cumming, GA 30040

If the complaint is not resolved to the patient's satisfaction, he/she has a right to file a grievance with the Healthcare Facility Regulation Division, Department of Community Health, Complaints Unit or Accreditation Association for Ambulatory Health Care (AAAHC) for concerns against the surgery center, the Georgia Composite Medical Board concerning the physician or the Professional Licensing Boards Division, Georgia Board of Nursing with concerns against any of the nursing staff. The patient should provide the physician or surgery center name, and address and the specific nature of the complaint.

COMPLAINTS AGAINST THE ASC:

Healthcare Facility Regulation Division
Department of Community Health
Attn: Complaints Unit
2 Peachtree Street, N.W., Suite 31-447
Atlanta, Georgia 30303-3142

P: (800) 878-6442
F: (404) 657-8935

ONLINE:
https://dch.georgia.gov/divisionsoffices/healthcare-facility-regulation/facility-licensure/hfr-file-complaint

AAAHC
5250 Old Orchard Road, Suite 200
Skokie, Illinois 60077

P: (847) 853-6060
F: (847) 853-9028

E-mail: info@AAAHC.org

COMPLAINTS AGAINST THE PHYSICIAN:

Georgia Composite Medical Board
Enforcement Unit
2 Peachtree Street, N.W., 6th Floor
Atlanta, Georgia 30303

P: (404) 656-3913, select option #3
F: (404) 656-9723

ONLINE: https://gcmb.mylicense.com/verification/Search.aspx?SubmitComplaint=Y

COMPLAINTS AGAINST NURSING STAFF:

Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217-3858

P: (844) 753-7825

ONLINE:
http://verify.sos.ga.gov/verification/Search.aspx?SubmitComplaint=Y

ISSUES REGARDING MEDICARE:
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
or call 1-800-MEDICARE

I verify I have received and understand the information regarding Patient Rights and Responsibilities, Patient Privacy and Grievance Procedures.

Patient/Guardian Signature	Relationship to Patient	Date/Time

CLEAVER MEDICAL GROUP SURGERY CENTER

NOTICE OF PRIVACY PRACTICES
EFFECTIVE MAY 2021

HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the facility may be billed to and payment may be collected from you, an insurance company or a third party.

For Treatment. We may use medical information 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 people who are involved in taking care of you at the facility or the hospital.

For Health Care Operations. We may use and disclose medical information about you for health care operations such as quality improvement efforts. These uses and disclosures are necessary to run the facility and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other facility personnel for review and education purposes.

WHO WILL FOLLOW THIS NOTICE. Any health care professional authorized to enter information into your medical chart including all facility doctors, nurses and personnel will abide by this notice.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the facility. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel or by your doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include appointment reminders; as required by law; for public health-related benefits and services; to individuals involved in your care or payment for your care; research; and to avert a serious threat to health or safety. Other uses and disclosures of your personal information could include disclosure to, or for: medical examiners; law enforcement; lawsuits and disputes; military and veterans; national security; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" listing the disclosures we have made of medical information about you.

Right to Amend. If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Administrator, and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care.

Right to 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.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way. You must make your request in writing, and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint. ***You will not be penalized for filing a complaint.***

COMPLAINTS AGAINST THE ASC:

Healthcare Facility Regulation Division
Department of Community Health
Attn: Complaints Unit
2 Peachtree Street, N.W., Suite 31-447
Atlanta, Georgia 30303-3142

P: (800) 878-6442
F: (404) 657-8935

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ISSUES REGARDING MEDICARE:
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
or call 1-800-MEDICARE

CHANGES TO THIS NOTICE. We reserve the right to change this notice. A copy of the current notice will be posted in the waiting room.

If you have any questions about this notice or need further information, please contact: Ashley Dorsey, Administrator at (770)746.6380.

CLEAVER MEDICAL GROUP SURGERY CENTER

CONSENT AND TREATMENT AUTHORIZATION

I hereby consent to the rendering of such care and treatment as the physicians and medical staff of Cleaver Medical Group Surgery Center consider to be necessary and appropriate. The consent to receive medical treatment includes, but is not limited to, examinations, diagnostic and therapeutic procedures, medications, anesthesia, and any other medical treatment and services which I may require. I hereby acknowledge that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may involve risk of injury and of adverse results. I hereby acknowledge that no guarantees have been made to me as to the results of the procedures, which I may undergo while a patient of Cleaver Medical Group Surgery Center.

ACKNOWLEDGEMENT OF PATIENT

I understand that:

- **a)** my physician or Cleaver Medical Group Surgery Center may permit one or more observers to be present during my surgery for educational, accreditation or licensing purposes. Photography of my surgery may occur at my physician's discretion.
- **b)** I should not drive until the effects of any medication received have worn off. I must have a responsible adult drive me home if I received sedation.
- **c)** the Cleaver Medical Group Surgery Center is not responsible for the loss of or damage to any article of value brought to the facility.
- **d)** because of the possible adverse effects of some medications on an unborn fetus, it is important to know if I am pregnant. Therefore, I certify that to the best of my knowledge, I am NOT pregnant.

ADVANCE DIRECTIVES

Cleaver Medical Group Surgery Center will ask me if I have executed an advance directive. I am aware that Cleaver Medical Group Surgery Center typically treats healthy patients undergoing elective procedures. Therefore, the extent to which my Advance Directive specifies may be limited. I consent to resuscitative measures as deemed necessary by my physician in the event of a life-threatening emergency. I consent to emergency transfer to Northside Forsyth Hospital in case of the need for emergency hospital care. A copy of my Advance Directive, if provided, will be placed on my chart, and transferred to the hospital in the event of a transfer. Information regarding Advance Directive has been made available to me preoperatively. Northside Forsyth Hospital is not affiliated or in partnership with Cleaver Medical Group Surgery Center.

OWNERSHIP

I understand that Cleaver Medical Group Surgery Center is owned by Miranda Reed, DO (100%). I have been given the option of having my surgery at a facility not owned by physicians and choose to have my surgery at Cleaver Medical Group Surgery Center.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated, and reported to the Administrator of Cleaver Medical Group Surgery Center. Any substantiated allegation will be reported to the State and/or local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within (20) days of receipt of the grievance. The contact information for the State of Georgia is included on the Patient Bill of Rights that I received. The patient will be advised of the grievance status throughout the process.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the request and/or release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary for processing insurance claims, utilization review, quality assurance activities or continuity of care. This authorization applies to all healthcare providers involved in my treatment at the facility.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I hereby assign to Cleaver Medical Group Surgery Center all surgical, medical insurance and/or other benefits for services rendered by Cleaver Medical Group Surgery Center. It is the policy of Cleaver Medical Group Surgery Center to collect payment at the time of service. Cleaver Medical Group Surgery Center will file a claim to my insurance. I am aware that any charges NOT COVERED by my insurance policy, including co-insurance and deductible, are my responsibility. I understand that my insurance company may send payments for the rendered services to me. I agree to endorse the insurance check(s) over to Cleaver Medical Group Surgery Center. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud.

I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT.

Patient/Guardian Signature: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____Time: _____

Patient Name: _____

CLEAVER MEDICAL GROUP
SURGERY CENTER

COVID-19 Policy

Patient Screening:

Every patient will be screened for COVID-19 symptoms upon arrival for their scheduled procedure. **It is MANDATORY that ALL patients have their temperature taken upon entry into the surgery center**. If anyone has a temperature of 100.4 or greater, they will be rescheduled.

Patients are also screened during appointment reminder calls. If the patient answers "yes" to any of the screening questions, they will need to be rescheduled.

Mask Protocol:

Vaccinated or not we require universal masking. Patients MUST wear a mask at all times while in the facility. If patients choose to not wear a mask, they will be rescheduled.

Cleaning/Disinfecting:

- Waiting rooms will be cleaned frequently.
- Our exam rooms and treatment rooms are to be cleaned and disinfected frequently, including before and after each patient.
- Hand sanitizer is available.
- Wash hands frequently.
- Doctors, nurses, and all medical staff members should sanitize or wash their hands before and after interacting with patients.

Social Distancing & Visitors:

- We will not be allowing any visitors during this time.
- Drivers are allowed to come in upon arrival to obtain signature, they will then be asked to wait in the car while procedure is being performed.

Risks:

I understand that various aspects of the procedure, that may include going under anesthesia, performing an invasive procedure (surgery or injection), administration of steroids, and being near other people (medical staff, other patients) all may increase my risk. These risks include higher chance of exposure to the corona virus, developing COVID-19 infection, and getting sicker from the virus, than if I did not have the procedure performed. I understand that COVID-19 can cause severe illness and death.

My doctor and I have determined that at this time, this procedure is medically necessary for my health and well-being and is an elective procedure. We agree that if we wait until the pandemic has resolved, this will probably lead to worsening of my medical condition. I understand and accept these increased risks, and I understand that these risks are in addition to the standard risks associated with this procedure

CLEAVER MEDICAL GROUP
SURGERY CENTER

Anticoagulant "Blood Thinner" Instructions

Some medications need to be stopped prior to certain procedures. If you are taking a blood thinning medication, we must have clearance from the prescribing physician that it is ok for you to stop taking a blood thinning medication.

For your safety, do not stop taking these medications before approval is received from your prescribing physician.

Blood Thinner Restrictions for Epidural and Cervical Procedures				
7 days	**5 days**	**3 days**	**1 day**	**8 hours**
	Coumadin/Jantoven (Warfarin)	Pletal (Cilostazol)	Lovenox (enoxaparin)	*SubQ heparin*
Plavix (Clopidogrel)	Arixtra (fondaparinux)	Savaysa (edoxaban)	Fragmin (dalteparin)	
Effient (Prasugrel)	Pradaxa (dibigatran)	Xarelto (rivaroxaban)	Aggrastat (tirofiban)	
Trental (Pentoxifylline)	*Brillinta (Ticagrelor)*		Integrelin (eptifibatide)	
Aspirin	Aggrenox (Aspirin/Dipyrimidole)			
	Eliquis (apixaban)			

Major Procedures (Procedures requiring an incision) and Trials *To include above instructions if applicable*	
7 days	Fish oil, Vitamin E, Ginkoba, NSAIDs, and/or Aspirin

If your blood thinner medication is not in the above table, please contact your doctor for further information regarding management.

CLEAVER MEDICAL GROUP
SURGERY CENTER

Diabetic Pre-op Instructions

- It is crucial that your blood glucose level is optimized prior to the procedure.
- We will make every effort to schedule diabetic patients early in the morning
- Steroid injections may **elevate your blood sugar** after your procedure. After the injection, **check your blood sugar** frequently for next **2-3 days** and adjust as necessary. You may have to notify your doctor who treats your diabetes so the blood sugar can be treated appropriately.
- Your blood glucose will be measured when you arrive on your procedure day. **Your fasting blood glucose level should be less than 180 mg/dL**. **If your blood glucose is more than 200 mg/dL your procedure may need to be rescheduled**. Your doctor will make the final determination.
- Oral diabetic medications (e.g., metformin) should not be taken on the morning of your procedure until normal diet is resumed
- If you are on intermediate insulin, you should take 50% of your morning dose
- If you have any questions regarding your diabetic medications, please speak to your prescribing doctor

CLEAVER MEDICAL GROUP
SURGERY CENTER

Sacral Medial Branch Block Injection Pre-Procedure Instructions

You are scheduled for a Sacral Medial Branch Block Injection at Cleaver Medical Group ASC on _____ at _____.
(Date) (Time)

- Please arrive 30 minutes before your scheduled procedure time. Bring your photo ID, insurance card(s), and required payment (co-pay, co-insurance, deductible).

- Please have a responsible driver over the age of 18, who can stay in the surgery center waiting area for the duration of your procedure. Uber and taxi drivers can be used to provide transportation, but you must have a responsible adult who will be with you to accompany you home afterwards.

- If you take a prescription blood thinner/anticoagulants, please stop **BEFORE** your procedure in the following time frames:

    - Plavix (Clopidogrel) - Patient will need to stop 7 days before the procedure.
    - Coumadin (Warfarin) - Patient will need to stop 5 days before the procedure.
    - Xarelto (Rivaroxaban) - Patient will need to stop 3 days before the procedure.
    - Eliquis (Apixaban) - Patient will need to stop 5 days before the procedure.
    - Pletal (Cilostazol) - Patient will need to stop 3 days before the procedure.
    - Pradaxa (Dabigatran Etexilate) -Patient will need to stop 5 days before the procedure.
    - Brillinta (Ticagrelor) - Patient will need to stop 5 days before the procedure.
    - Arixtra (Fondaparinux) - Patient will need to stop 4 days before the procedure.
    - Dipyridamole (Persantine) - Patient will need to stop 2 days before the procedure.
    - Aspirin - Patient will need to stop 7-10 days before the procedure.

- If you have been started on an antibiotic by another physician for an active infection, please notify our office 24 hours before your scheduled procedure.

- If you take diabetic medications, you will need to hold oral diabetic medications the day of the procedure and if taking long-acting medications, please take ½ the dose the night before the procedure. If taking Insulin please utilize the current regimen.

Failure to adhere to these guidelines will result in us not being able to perform your procedure.

Patient Name (Printed): _____ DOB: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

CLEAVER MEDICAL GROUP
SURGERY CENTER

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After Hours On-Call Physician: (762) 366-0800

Sacral Medial Branch Block Discharge Instructions

PATIENT NAME: _____ DOB: _____

- When having a Medial Branch Block (neck, mid-back, low-back, sacrum), you may experience leg or arm weakness. Please use caution when walking, especially going up or down stairs. This will go away once numbing medication has worn off.

Complications: Report any unusual symptoms to your Pain Management physician including

- Bleeding that does not stop
- Pain not relieved by medications
- Nausea and vomiting
- Swelling that continues
- Fever (Temperature of 101F or higher)
- Headache

Treatment/Self Care:

- **DO NOT** use heat at the site of injection for 24 hours after the procedure.
- You may have discomfort following injection. You may apply ice, on for 20 minutes, off for 20 minutes if desired
- Avoid any activity that causes pain or discomfort
- Keep injection site clean and dry for 24 hours
- You may remove procedure bandages/dressings this evening

Activities:

- The day of your procedure-go home and rest/light activity
- The following day-you may be up as tolerated and resume daily activity
- **DO NOT** drive or operate machinery for 24 hours if you have had sedation or experience leg weakness.
- **DO NOT** make important decisions for 24 hours if you have had sedation.

Diet:

- No alcohol ingestion for 24 hours
- Resume normal diet as tolerated

You may call a member of our surgery center staff at **(770) 872-6179** Tuesday and Wednesday 8:00 AM -5:00 PM or our main office at **(770) 800-3455** Monday – Friday 8:00 AM – 5:00 PM. We will return all non-emergency messages within 24 hours. To reach our provider on-call after hours, please call **(762) 366-0800.** If you are experiencing an emergency or can't reach a member of our staff, go to your nearest Emergency Room for evaluation and treatment. ***Remember*** you may be sore the morning following the procedure, but you should feel better later in the day.

Patient Name (Printed): _____ DOB: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____