Center For Specialty Care, Inc.
50 East 69th Street
New York, New York 10021
Telephone (212) 249-8000
Fax (212) 249-7300

ADMISSION SHEET FORM B

1. AUTHORIZATION TO RELEASE INFORMATION
   I/We authorize release of medical information as required for collection of benefits from insurance carriers or other third party sources of payment in connection with the illness or injury of the patient.
2. MEDICARE/MEDICAID PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST
   I/We certify that the information given to me in applying for payment under Title XVII and, or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf to the Center For Specialty Care, Inc. I understand that I am responsible for any health insurance deductibles and coinsurance.
3. ASSIGNMENT OF INSURANCE BENEFITS
   I/We authorize payment directly to the Center For Specialty Care, Inc. arising from insurance through which the patient is insured and which the patient is insured and which are otherwise payable by me, but not to exceed the amount charged for the services provided.
4. GUARANTEE OF PAYMENT
   For and in consideration of services rendered or to be rendered to this patient by the Center For Specialty Care, Inc. I/We hereby guarentee payment of any and all bills rendered for said patient which are not covered or allowableby insurance, together with all collection costs, including a reasonable attorney fee for the providers listed above in the event it becomes necessary for them to file suit to effect payment. I understand that all bills are payable and become due in full receipt of the 60 day billing statement. I understand that fee information provided to me before services are provided in an estimate.

DATE:_____ SIGNATURE:_____
(Parent or legal guardian if patient is a minor)

Relationship to Patient:_____

Surgery Date	Patient's Name(First-Middle-Last)	S	Birthdate	Age	SSN

Street Address	City,State	Zip Code	Telephone
Notify in Case of Emergency	Telephone	Surgeon	Referring Physician
1st Responsible Party Name	Telephone	2nd Resonsible Party Name	Telephone
Street Address	City,State	Street Address	City,State,Zip
Zip Code / SSN	Relationship	Zip Code / SSN	Relationship
Employer	Occupation	Employer	Occupation
Employer's Address		Employer's Address	
City,State,Zip		City,State,Zip	
Patient Full Name		Accident Date	Medical Record Number NOT SET

Primary Subscriber Name(First-Last)	Ins.Code	Insurance Carrier	Ext.reference/Pre-Cert/Auth #
Primary Insurance Carrier Address			Group Number / Policy Number
, ,			
Secondary Subscriber Name	Ins.Code	Insurance Carrier	Ext.reference/Pre-Cert/Auth #
Secondary Insurance Carrier Address			Group Number / Policy Number
, ,			

CENTER FOR SPECIALTY CARE, INC.
50 East 69th Street, New York, New York 10021
Tel. 212-249-8000 Fax 212-249-3321

Patient's Medication List (Please Print Legibly)

Medication	Dosage	# Times a day	Medication Use	Continue at home	Stop Meds	MD Initials
FOR OFFICE USE ONLY						
New Medication Dispensed	**Dosage**	**# Times a day**	**Medication Use**	**Continue at home**	**Stop Meds**	**MD Initials**

_____
MD Signature

Please fill out medications, dosages prescribed with, and how many times a day. Also include herbs, Vitamins, Minerals, and any other Supplements that you are currently taking.

Patient name _____ **Signature** _____

Date _____

The Center for Specialty Care
50 E69th Street
New York, NY 10021
(212) 249-8000
(212) 249-7300 Fax

PLEASE READ THIS STATEMENT & AGREEMENT CAREFULLY

The Center for Specialty Care staff has contacted your insurance company to verify your benefits. The information obtained during this phone call includes your policy deductible, co-insurance, percentage of coverage and pre-certification requirements. Our billing policy is to collect the ***estimated*** deductible/coinsurance charges discovered during the confirmation of benefits phone call on the day of service. Patients are notified prior to their date of service of this patient responsibility. ***(Under certain circumstances, the patient may not be able to be contacted and as a result, they may be unprepared to make payment on the date of service.)*** In the event that the estimated charge collected is more than your responsibility after claim processing, we will refund you any account overpayment. However, if the patient responsibility collected is less than what was estimated, you will be balance billed for the difference. Therefore, please sign this statement confirming that you understand that you will be balance billed for any charges applied to your patient responsibility by your insurance.

I certify that I will make payment for any insurance deductible or co-insurance or any other related expenses (Denied Charges, i.e. coverage termination, charges not deemed medically necessary, pre-existing limitations) that will be billed for my procedure at the Center for Specialty Care.

Please note this charge is separate from the Surgeon's charge and Anesthesia

---

Patient Name (Please Print) _____

Signed _____

Date of Service _____

CENTER FOR SPECIALTY CARE, INC.
50 East 69th Street
New York, NY 10021
Telephone (212) 249-8000
Fax (212) 249-3321

FORM E
PATIENT HEALTH QUESTIONNAIRE

Please take a moment to carefully answer the following questions. Place a check mark in the YES/NO column or write your response on the appropriate line. This information will be reviewed by your anesthesiologist prior to surgery and help in preparing and conducting a safe anesthetic for you. Thank You.

Name _____

Age: _____ Height: _____ Weight: _____

Telephone Number: _____

Current medical doctor (Internist): _____

1. Do you take Aspirin? [ ]Yes [ ]No
2. How much do you smoke (packs a day)? _____
3. How much alcohol do you drink in a week? _____
4. List all operations that you have had and note the year of surgery.

_____

_____

_____

_____

5. Have you been hospitalized for any other medical conditions?

_____

6. Have you had any problems with anesthesia in the past?
   Describe _____
7. Do you have allergies to any medications? (Include eggs/soybean, latex, rubber, condoms)
   List them: _____

		Yes	No
8.	Do you have any loose teeth, dentures or caps		
9.	Do you wear contact lenses?		
10.	Have there been any anesthetic related problems in your family?		
11.	Past history of drug abuse?		
12.	Do you have high blood pressure?		
13.	Do you get chest pain (angina)?		
14.	Have you had a heart attack or congestive heart failure?		
15.	Do you get palpitations?		
16.	Have you ever had rheumatic fever?		
17.	Do you have a heart murmur?		
18.	Any significant mitral valve prolapse?		
19.	Do you have a pacemaker defibrillator?		
20.	Do your legs (calves) get cramps when you walk a short distance?		
21.	Do you get short of breath if you do not sleep on 2 or more pillows?		
22.	Have you had a recent sore throat or chest cold?		
23.	Do you have asthma, bronchitis, emphysema or history of pneumonia?		
24.	Have you been treated for TB?		
25.	Do you have stomach problems (ulcer or heartburn)?		
26.	Do you have a hiatal hernia?		
27.	Have you ever been treated for anemia?		
28.	Do you have Sickle Cell anemia or a trait?		
29.	Do you bruise or bleed easily?		
30.	Have you ever had a transfusion?		
31.	Have you ever had kidney failure, stones, or infection?		
32.	Do you have thyroid disease?		
33.	Do you have diabetes (how long)?		
34.	Do you have liver disease (cirrhosis or hepatitis?		
35.	Do you have arthritis of your jaw, neck, or back?		
36.	Do you have difficulty opening your mouth?		
37.	Do you have epilepsy (seizures)?		
38.	Have you ever had a stroke or temporary blackout?		
39.	Do you take birth control pills?		
40.	Could you be pregnant?		
41.	Date of last menstrual period.		
42.	Have you had a significant weight loss in the last six months without dieting?		
43.	Do you have or have been diagnosed with Sleep Apnea?		
44.	If yes, Do you use CPAP?		

Please sign below when you have completed this form to the best of your knowledge and are satisfied that you understand the questions.

Signature _____ Date _____

PHYSICIAN: SEND TO CENTER PRIOR TO SURGERY

CENTER FOR SPECIALTY CARE, INC.
212-249-8000

PATIENT RIGHTS:

1. Understand and use these rights. If for any reason you do not understand or you need help, the ambulatory surgery center must provide assistance, including an interpreter, if possible.

2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment

3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

4. Receive emergency care if you need it.

5. Know the names, positions and functions of any staff involved in your care and refuse their treatment, examination or observation.

6. Receive complete information regarding your diagnosis, treatment and prognosis.

7. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

8. Refuse treatment and be told what effect this may have on your health.

9. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

10. Privacy while in the Center, and confidentiality of all information and records regarding your care.

11. Participate in all decisions about your treatment and discharge and be given a written discharge plan.

12. Review your medical record without charge. Obtain a copy of your medical record, for which the Center can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

13. Receive an itemized bill and explanation of all charges.

14. Complain without fear of reprisals about the care and services you are receiving and to have the Center respond to you and if you request it, be given a written response. If you are not satisfied with the response, you can complain to the New York State Health Department. The State Health Department telephone number is 212-613-4855.

PATIENT'S RESPONSIBILITIES:

As a patient you have the responsibility to:

1. Provide your physician(s) and the Center staff with accurate information related to your condition and care. You are responsible for telling your doctor your medical and surgical history, whether you have been hospitalized in the past, what for, and what medications you are now taking or have with you.

2. Tell your doctor or nurse if there is a change in your condition or if problems arise in your treatment.

3. Tell your doctor or nurse if you do not understand your treatment or any instructions given to you.

4. Follow the treatment plans. Patients are responsible for medical consequences which result from refusing treatment or not following instructions of physicians and Center staff.

5. Use Center equipment and facilities carefully, so that they remain in good condition for use by others.

6. Exhibit behavior that is respectful of the physicians, staff and other patients.

7. Observe that smoking is not permitted in the Center.

8. Supply all necessary insurance information and pay your bill promptly so that the Center for Specialty Care can continue to serve others effectively.

9. To assure that there is an adult escort available to accompany them at the time of discharge

ADVANCE DIRECTIVE NOTIFICATION:

In the State of New York, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorizes others to make decisions on their behalf, based on the patient's expressed wishes when the patient is unable to make decisions to communicate decisions. Center for Specialty Care, Inc. respects and uphold those rights.

However, unlike an acute care hospital setting, the Surgery Center does not routinely perform "high risk" procedures Most procedures performed in this facility are considered to be of low risk. Of course, no surgery is without risk. You will discuss the specifics of your procedures with your physician who can answer your questions as to its risks, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure elsewhere.

If a patient is adjudged incompetent under the states laws, the rights of the patient are exercised by the person appointed and/or the legal representative designated by the patient under New York State law to act on the patient's behalf. The center will accept a Court Appointed Guardian, Dual Power of Attorney, or a Health Care Surrogate.

PATIENT COMPLAINT OR GRIEVANCE:

1. If you have a problem or complaint, please speak to the receptionist or your care giver. We will address your concern(s) promptly.

2. If necessary, your problem or complaint will be advanced to the Administrator and/or Medical Director for resolution. You will receive a letter or phone call to inform you of the actions taken to address your complaint.

3. If you are not satisfied with the response of the surgery center, you may contact:

Patient complaints or grievances against an ambulatory surgical center may be filed through the State of New York at 1-800-804-5447 or write to the address below:

New York State Department of Health
Centralized Hospital Intake Program
433 River Street, Suite 303
Troy, NY 12180-2299

If you have a complaint against a health care professional and want to received a complaint form, call 1-800-633-6114 or write to the address below:

New York State Department of Health
Office of Professional Medical Conduct
433 River Street, Suite 303
Troy, NY 12180-2299

You may also contact AAAHC by mail at:

AAAHC, Inc.
5250 Old Orchard Road, Suite 200
Skokie, IL 60077

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage at:

www.cms.hhs.gov/center/ombudsman

DISCLOSURE OF OWNERSHIP:

The Center for Specialty Care, Inc. is a corporate entity privately owned by the family of and operated by the late Dr. James W. Smith.

Your physician does not have any ownership at the Center For Specialty Care, Inc. Your physician is credentialed by the Center to perform cases, as an attending at a free-standing private Ambulatory Surgery Center.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS:

By: _____ Date Notice Received: _____

(Patient/Patient representative Signature)

CENTER FOR SPECIALTY CARE, INC.
50 EAST 69TH STREET
NEW YORK, N.Y. 10021

TEL: 212-249-8000
FAX: 212-249-7300

NOTICE OF PRIVACY PRACTICES

I have:

☐ received ☐ refused a copy of the Center's Notice of privacy practices.

Patient Signature **Date**

At the request of the New York State Department of Health, the Center requests that each patient indicate their Race & Ethnicity below. This is not a DOH or Center requirement. You may refuse. However, as a part of its statewide data collection process for all hospitals and ambulatory surgery centers, the DOH asks that we ask you to do this, if you are willing. If you are, please indicate both your Race & Ethnicity origin below. If not, you may ignore our request. Thank you.

Patient Race:

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ White
- ☐ Other Race

Patient Ethnicity:

- ☐ Not of Hispanic, Latino/a, or Spanish Origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic, Latino/a, or Spanish Origin
- ☐ Unknown

Advance Directives:

- ☐ Yes
- ☐ No

CENTER FOR SPECIALTY CARE
PATIENT NOTICE OF PRIVACY PRACTICES

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

I. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Your health record is the physical property of the Center for Specialty Care. The information contained in the record, however, belongs to you. You have the right to:

A. Request a restriction or limitation on the medical information we use or disclose about you for your 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 requested restrictions. If we do not agree, we will comply with your request unless the information is needed to provide you emergency treatment.

B. Obtain a copy of this Notice by requesting it from the Executive Director of the surgery center.

C. Inspect and obtain a copy of your health care record by submitting a request in writing to the Medical Record Department of the Center for Specialty Care.

D. Amend your healthcare record if you feel that medical information that we have about you is incorrect or incomplete by requesting, in writing, that an amendment be made. You must provide a reason that supports your request.

E. Obtain a report of all of the disclosures of your health information that we have made.

F. Request that we communicate with you about your medical information in a certain way or at a certain location.

G. Revoke your authorization to use and disclose medical information about you, except to the extent that we have already used or disclosed your medical information.

II. OUR RESPONSIBILITIES REGARDING YOUR MEDICAL INFORMATION

We are required by law to:

A. Maintain the privacy of your health information.

B. Provide you with this Notice, which describes our legal duties and privacy practices with respect to information we collect about you.

C Abide by the terms of this Notice.

D. Notify you if we are unable to agree to a requested restriction

E. Accommodate reasonable requests that you have made to have us communicate your health information to you in a certain way or a certain location.

WE RESERVE THE RIGHT TO CHANGE THIS NOTICE. We reserve the right to make the revised and changed notice effective for medical information that we already have about you, as well as any information we receive in the future. We will post a copy of the current notice in the Center. The notice will contain the effective date on the first page. Each time you register at the Center for Specialty Care for health care services, we will offer you a copy of the current notice in effect.

III. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

Each time you visit us a record of your visit is made. We may use or disclose the health information contained in this record. The following categories describe the different ways that we may use and disclose your medical information.

A. Treatment. We may use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians, or other surgery center personnel who are involved in taking care of you at the surgery center.

For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health team. Member of your healthcare team will then record the actions that they took and their observations. By reading your medical record, the physician will know how you are responding to treatment.

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

C. Health Care Operations. We may use and disclose medical information about you for the operations of the Center for Specialty Care.

For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will be used in a way to improve the quality and effectiveness of the healthcare and services that we provide.

D. Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the surgery center.

E. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

F. Health-Related Benefits and Services. We may use and disclose medical information to inform you about health-related benefits or services that may be of interest to you.

G. Individuals Involved in Your Care or Payment of Your Care We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care

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

I As Required by Law We will disclose medical information about you when required to do so by federal, state or local law

J. Emergency. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. The Center for Specialty Care, however, would only disclose the information to someone able to help prevent the threat.

K. Organ and Tissue Donation. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

L. Business Associates. Some of the services provided at the Center for Specialty Care are provided by business associates. For example, we contract with certain laboratories to perform lab tests. When we contract for these services, we may disclose your health information to our business associates so that they can perform the job we have hired them to do. To protect your health information, we require our business associates to appropriately safeguard your information.

M. Workers' Compensation. We may release medical information about you to the extent authorized by and to the extent necessary to comply with the laws relating to workers' compensation or other similar programs established by law.

N. Public Health Risks. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

O. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

P Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in a dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Q. Law Enforcement. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

R. Coroners, Medical Examiners and Funeral Directors We may release medical information to a coroner or medical examiner. We may also disclose health information to funeral directors consistent with applicable law to carry out their duties.

S Food and Drug Administration. We may disclose to the FDA health information related to adverse events with respect to food, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement

T. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

IV. OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only upon written authorization you provide to us If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will not longer use or disclose medical information about you fore the reasons covered by your written authorization. The revocation, however, will not have any affect on any action the Center for Specialty Care took before it received the revocation

V. QUESTIONS OR COMPLAINTS

If you have questions and would like additional information, you may contact Beth Goldman, Chief Privacy Officer, (212) 452-5160 at the Center for Specialty Care.

If you believe your privacy rights have been violated, you can submit a written complaint describing the circumstances surrounding the violation to Sebastian Damiani, Executive Director, (212) 452-5157 at the Center for Specialty Care or the Secretary of Health and Human Services. You will not be penalized for filing any complaints.

The Center for Specialty Care, Inc.
50 E 69th Street
New York, NY 10021
(212) 249-8000

Patient Name: **Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Items or Services:	Colonoscopy Colonoscopy with biopsy and or polyp removal Upper gastrointestinal endoscopy Upper gastrointestinal endoscopy w/biopsy Flexible sigmoidoscopy Routine physicals and most tests for screening Cosmetic Surgery Surgical procedure not approved by Medicare to be preformed in an ASC setting	
Reason Medicare May Not Pay:	Medicare ultimately determines whether your procedure is deemed a medical necessity. This cannot be determined until the claim is received by Medicare and reviewed by their claims department.	
Estimated Cost:	Colonoscopy	$469.92
	Colonoscopy with biopsy and or polyp removal	$469.92
	Upper gastrointestinal endoscopy	$427.59
	Upper gastrointestinal endoscopy w/biopsy	$427.59
	Flexible sigmoidoscopy	$114.56
	Cosmetic surgery	*Based on surgical OR time
	Surgical procedure not approved by Medicare	*Based on current MC fee schedule

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options:	**Check only one box. We cannot choose a box for you.**
❑	**OPTION 1.** I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
❑	**OPTION 2.** I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
❑	**OPTION 3.** I don't want the _____ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

For Medicare Patients only

Northeastern Anesthesia Services, 118 N. Bedford Rd, Mt Kisco NY 10549 (914) 666-8866

Patient Name: _____ (billing office use only): _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **the service** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **service** below.

Service	Reason Medicare May Not Pay:	Estimated Cost
Administration of intravenous Propofol sedation and Monitored Anesthesia Care	Medicare considers the use of intravenous Propofol sedation and Monitored Anesthesia Care not medically necessary unless there are specific risk factors or significant medical conditions present.	$165.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **service** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **service** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **service** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **service** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

Medicare Patient's only

MEDICARE QUESTIONNAIRE

You are completing this form in order to assist your anesthesiologist in determining the need for intravenous Propofol sedation, which we believe to be the preferred anesthetic technique for your procedure. We will bill your Medicare insurance carrier in our usual and customary way and alert you to any issues that may arise.

NAME: **DOB:**	**DATE:**	
1. Are you a smoker?	☐ Yes	☐ No
2. Do you have heart disease? (chest pain, a prior heart attack, valvular disease, palpitations, other _____)	☐ Yes	☐ No
3. Do you have lung disease? (COPD, pneumonia, bronchitis, emphysema, asthma, other _____)	☐ Yes	☐ No
4. Do you have diabetes?	☐ Yes	☐ No
5. Do you have symptoms of a hiatal hernia or of reflux disease?	☐ Yes	☐ No
6. Do you have kidney or liver disease? (cirrhosis, hepatitis, renal failure, other _____)		
7. Do you have thyroid disease?	☐ Yes	☐ No
8. Have you ever had a stroke or "mini" stroke/TIA?	☐ Yes	☐ No
9. Do you have any neurological diseases? (MS, epilepsy, other_____)	☐ Yes	☐ No
10. Do you take tranquilizers or narcotics more than once per week? (Percocet, Vicodin, Tylenol III, other _____)	☐ Yes	☐ No
11. Are you very anxious prior to medical procedures preventing you from remaining motionless when requested?	☐ Yes	☐ No
12. Are you treated for depression or other mental illness?	☐ Yes	☐ No
13. Do you have a low pain threshold?	☐ Yes	☐ No
14. Have you abused drugs or alcohol?	☐ Yes	☐ No
OBSTRUCTIVE SLEEP APNEA SCREEN (STOPBANG)		
15. Do you snore loudly (have you been told this)?	☐ Yes	☐ No
16. Are you very tired during the day?	☐ Yes	☐ No
17. Have you been told you stop breathing for short periods of time during sleep?	☐ Yes	☐ No
18. Do you have high blood pressure?	☐ Yes	☐ No
19. Are you overweight? (BMI >35)	☐ Yes	☐ No
20. Are you over 50?	☐ Yes	☐ No
21. Is your neck circumference over 16 inches?	☐ Yes	☐ No
22. Are you male?	☐ Yes	☐ No

SIGNATURE: _____ **IF LESS THAN 3 CHECKED "YES" PLEASE SIGN BACK**

Center for Specialty Care, Inc.
50 East 69th Street, New York, NY 10021
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Screening Questionnaire for Latex Sensitivity

1. Name.....
2. Date of Birth.....
3. Have you ever been told by a doctor that you are allergic to latex?.....☐Yes ☐ No
4. How many surgeries have you had in the past? (List all surgeries)
   .....
5. Do you suffer from:
   - Seasonal hay fever?.....☐Yes ☐ No
   - Asthma?.....☐Yes ☐ No
   - Eczema?.....☐Yes ☐ No
   - Autoimmune disease.....☐Yes ☐ No
6. Do you have on-the-job exposure to latex?.....☐Yes ☐ No
7. Were you born with problems involving your spinal cord?.....☐Yes ☐ No
8. Do you catheterize yourself to urinate?.....☐Yes ☐ No
9. Do you have any food allergies?.....☐Yes ☐ No
10. Are you allergic to bananas?.....☐Yes ☐ No
    - Kiwi fruits?.....☐Yes ☐ No
    - Avocados?.....☐Yes ☐ No
    - Guacamole?.....☐Yes ☐ No
    - Chestnuts?.....☐Yes ☐ No
11. Are you allergic to latex or products containing rubber? ☐Yes ☐ No

    For example:
    - History of spina bifida, urological reconstructive surgery
    - History of repeated surgical procedures (eg.,>9)
    - History of intolerance to latex-based products: balloons, rubber gloves, condoms, dental dams, rubber urethral catheters
    - History of intraoperative anaphylaxis of uncertain etiology

    If yes, are the symptoms a rash?
    - Hives?.....☐Yes ☐No
    - Itching?.....☐Yes ☐No
    - Wheezing?.....☐Yes ☐No
    - Difficulty breathing?.....☐Yes ☐No
    - Watery eyes?.....☐Yes ☐No
    - Anaphylaxis?.....☐Yes ☐No
12. Do you have allergic symptoms while:
    - Blowing up balloons?.....☐Yes ☐No
    - During dental examinations?.....☐Yes ☐No
    - On contact with diaphragms/condoms?.....☐Yes ☐No
    - During vaginal or rectal exams?.....☐Yes ☐No
    - While wearing rubber gloves?.....☐Yes ☐No