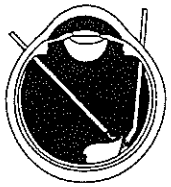

AUGUSTA RETINA-LASER
SurgiCare

Augusta Retina-Laser Surgicare (ARLS) is a separate entity that provides outpatient surgical services to our patients just like a hospital. All the procedures performed at this facility will be billed to the patients' respective primary insurance companies. This facility fee is separate from the professional service fee provided to the patient at the doctor's office. This means that our patients will receive two (2) separate bills; one from Southeast Retina Center, P.C. and one from Augusta Retina-Laser Surgicare.
I understand that I am required to have a competent companion accompany me to the Center and be available during and after my surgery and that I will be discharged to that person's custody and must rely on him or her for my return home.
I certify that I have had nothing to eat or drink 8 hours prior to the time of my surgery if applicable.
I CONSENT to the photographing, filming, or videotaping of the treatment of procedure of educational or diagnostic use.
I authorize disclosure of information to the manufacturers of devices subject to the Safe Medical Devices Act.
I understand that my physician owns the ambulatory surgical treatment center. I understand that I am free to choose another facility in which to receive the services that have been ordered by my physician. I also agree to adhere to the treatment plans recommended by my doctor, and to treat all staff members with respect. A copy of The Bill of Rights was received yes _____ no _____
I understand that this facility is an ambulatory surgical center and my physician has determined that the procedure can be performed in this facility. I understand that if an emergency condition should occur, I will be transferred to the closest hospital for further evaluation and treatment.
I understand that this facility does not honor advance directives or living wills. In the event of a transfer to another facility a copy of your living will, or advance directives will be sent to the transferring facility. I have advance directive or living wills yes _____ no _____ Copy of advance directive or living will received yes _____ no _____
I certify that I have read and fully understand the above consent treatment, that the explanations herein referred to are understood by me, that all my questions have been answered, that all blanks or statements requiring insertion or completion were filled prior to the time of my signature, and that this consent is given freely, voluntarily and without reservation. I understand that I have the right to refuse any medical and surgical procedures and treatment.
FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records for any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers).
Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or co-pay owed at the time of services. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys' fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law.

_____ Date _____
Full Signature of Patient/Parent/Guardian

_____ Date _____
Full Signature of Witness

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health-care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

Augusta Retina Laser Surgicare
PATIENT HEALTH QUESTIONNAIRE

Nickname _____ Occupation _____

Surgeon _____ Procedure _____

Family doctor/address _____ Any allergies _____

_____

LIST ALL OPERATIONS YOU HAVE HAD (OPERATION/DATE):

_____

_____ Date of last EKG _____

_____ Date of last Lab Work _____

Check the box only if you have had any of the following:

- ☐ Have you had any serious, life-threatening illness in the past?
- ☐ Have you had problems with anesthesia, other than nausea or vomiting?
  - ☐ Difficult intubation?
  - ☐ Malignant Hyperthermia?
  - ☐ Prolonged hospitalization due to anesthesia?
- ☐ Has a family member ever had problems with anesthesia other than nausea or vomiting?
  - ☐ Difficult intubation?
  - ☐ Malignant hyperthermia?
  - ☐ Prolonged hospitalization due to anesthesia?
- ☐ Have you had chest pressure, pain on exertion, or severe shortness of breath with exertion?
  - ☐ Unstable-frequency/duration
  - ☐ Awakening from sleep
- ☐ Have you had asthma or other problems with your breathing?
  - ☐ Recent (3 months) hospitalization or intubation, or predinisone use
  - ☐ Sleep apnea
- ☐ Have you have any problems with your heart or circulation?
  - ☐ Aortic Valve Disease (Stenosis)
  - ☐ Recent CHF within 1 month
  - ☐ MI within 6 months
  - ☐ High Blood Pressure
- ☐ Have you ever had diabetes/high blood sugar?
  - ☐ Hospitalized for glucose control within the past month?
- ☐ Have you ever had ulcers, a hiatal hernia, or frequent heartburn?
- ☐ Have you had a seizure disorder, stroke, or other neurological problems?
  - ☐ Stroke within the past month
  - ☐ Recent onset of seizures within 6 months or change in frequency/treatment
- ☐ Do you bleed easily? Frequently take aspirin or aspirin-like medication?
  - ☐ History of Von Willebrand disease
  - ☐ Hemophilia
  - ☐ H/O Bleeding after surgery
- ☐ Do you have any bleeding or clotting abnormalities such as easy bruising, excessive vaginal bleeding or tenderness of veins?
- ☐ Current weight _____ lbs
  - ☐ Are you more than 50 pounds overweight?
  - ☐ Morbid obese
- ☐ Recent wt. Loss? _____
- ☐ Recent diet? Type? _____
- ☐ Kidney or bladder disease, renal failure, dialysis?
  - ☐ Dialysis shunt/port location _____
- ☐ Hepatitis, jaundice, cirrhosis, HIV pos.
- ☐ Any foreign travel within last 6 months?
- ☐ Any exposure to infectious diseases?
- ☐ Up to date with Shots
  Pneumonia ☐ Yes ☐ No Influenza ☐ Yes ☐ No
- ☐ Have you ever had a blood transfusion?
  - ☐ If so, when?_____
- ☐ Do you have any implants, shunts? Where _____
- ☐ Do you drink alcohol? How much? _____
- ☐ Do you smoke?
  - ☐ How many per day? _____
- ☐ Have you ever abused or been addicted to any drug or mediation including alcohol, cocaine, marijuana, narcotics, sedatives, tranquilizers, hallucinogens, amphetamines, etc.? _____
- ☐ Do you have (please circle)
  False teeth, Loose teeth, Caps, Crowns, Dentures,
  Location _____
- ☐ Any back problems including previous surgery, fractures, and painful positions?
- ☐ Motion sickness?
- ☐ Have you had broken facial bones?
- ☐ Have you had nose or jaw surgery?

Female Patients

- ☐ Have you had a mastectomy? _____
- ☐ Are you pregnant? RH type _____
- ☐ Date of last menstrual period _____

Comments:

_____

_____

Interviewed By _____ (RN/LPN)

Date _____ Patient Sign: _____

**Your signature indicates a complete and correct medical history.*