Sequoia Surgical Pavilion

In Partnership with Physician Owners

PROPOSED PROCEDURE

Right Achilles Repair

SURGEON

Dr. Kou

SCHLEGEL, NIKOLAI
ID / Visit: 97281 / 1 Gender: M
DOB: 9/30/1970 Age: 51
Phys: KOU, JOSEPH
DOS: 8/31/2022

INFORMED CONSENT TO OPERATION AND OTHER MEDICAL SERVICES INCLUDING TRANSFUSION(S)

1. The facility maintains personnel facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of the facility, but independent contractors and, therefore, are the patient's agents or servants. The facility provides nursing and support services and facilities; the facility does not provide medical physician care.
2. The nature, purpose, and potential benefits of the listed procedure(s), as well as the possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me by my physician. I am aware that the practice of medicine and surgery is not an exact science and no guarantees have been made to me by anyone as to the results of the operation or procedure. I acknowledge that I have had the opportunity to discuss my concerns or questions with my doctor, and that my questions have been answered to my satisfaction.
3. My consent is given with the understanding that any operation or procedure involves risks and hazards. The more common risks include: infection, bleeding with the need for blood transfusion, nerve injury, blood clots, heart attack, stroke, allergic reaction, damage to teeth or bridgework, and pneumonia. These risks can be serious and possibly fatal.
4. I recognize that in an emergency or exceptional circumstances additional procedures, other than those specifically state above, may be necessary. I consent and request my physician and/or his designees to perform such procedures.
5. I authorize and direct the above named surgeon to arrange for such additional services for me as he or she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of pathology and radiology services, to which I hereby consent. In this event I consent to the release to the surgery center of all information and results regarding these services.
6. I authorize the pathologist or physician to use his or her discretion in disposing of any member, organ, implant, prosthetic, or other tissue removed from my person during the operation(s) or procedure(s).
7. **I DO / DO NOT** (circle one) authorize the administration of transfusions of whole blood or blood products to me as may be deemed advisable by the anesthesiologist, my attending physician and/or his associates or assistants. I understand that despite the exercise of due care the transfusion of blood or blood products is always attended with the possibility of some ill effects such as the transmission of hepatitis, HIV or certain other diseases, accidental immunization, or allergic reaction. I understand that in an emergency it may be necessary for the patient's well being to use existing stocks of blood which may not include the most compatible blood types. (*If the patient circles* **DO NOT,** *obtain the patient/guardian signature on the Refusal to Permit Blood Transfusion form).*
8. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV and Hepatitis.
9. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me following my surgery. I understand that I should not operate a motor vehicle, machinery or potentially dangerous appliances, drink alcoholic beverages, or make critical decisions for 24 hours or possibly later until the effects of my medications have worn off.
10. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual procedure.
11. I consent to the use of video-taping or photography that may be used for scientific or teaching purposes, and to the review of my medical record for bona fide medical healthcare research providing my name or identity is not revealed.
12. I release the facility from any responsibility for loss and/or damage to money, jewlery or other valuables I brought into the facility.
13. I understand that if I am pregnant or if there is any possibility I may be pregnant, I must inform the facility immediately since the scheduled procedure could cause harm to my child or to myself.
14. I am aware that my physician may have an ownership interest in the facility, and I acknowledge that I have a right to have the procedure performed elsewhere.
15. I understand in the rare event that hospitalization is required during or immediately after surgery, my physician will arrange for my transfer to a local hospital. In this event I consent to the release of all medical information from the admitting hospital to this facility.
16. I have not eaten or taken fluids, not even water, since DATE 8/30/22 TIME 2000 AM / PM except for a sip of water taken with medication as instructed by my physician.
17. My signature below constitutes my acknowledgement that (1) I have read or have had read to me the forgoing, and I agree to it; (2) the procedure(s) has been adequately explained by my physician; (3) I authorize and consent to the performance of the procedure(s) and any additional procedure(s) deemed advisable by my physician in his or her professional judgment; (4) I authorize and consent to the administration of anesthesia for the said procedure(s).
18. If I am not the patient, I represent that I have the authority of the patient who, because of age or other legal disability, is unable to consent to the matters above. I have fulll right to consent to the matters above, and I consent to same; (b) i hereby indemnify and hold harmless the facility, its emploees, agents, medical staff, partners and affiliates from any cost or liability arising out of my lack of adequate authority to give this consent.
19. I have received and reviewed the Patient Rights and Responsibilities.
20. I give the facility permission to leave a post operative follow up call message at the phone number (s) I have provided.

DATE 8/31/22 **TIME** 0805 **PATIENT'S SIGNATURE** [signature]

DATE 8/31/22 **TIME** 0805 **WITNESS TO SIGNATURE** [signature]

If patient is a minor or unable to sign complete the following

☐ Patient is a minor ☐ Patient is unable to sign because: _____

DATE _____ **TIME** _____ **SIGNATURE** _____

RELATIONSHIP _____

DATE _____ **TIME** _____ **WITNESS TO SIGNATURE** _____

White: MEDICAL RECORDS Yellow: PATIENT COPY

Rev.8/2017

I authorize and direct Hilzan, M.D. (anesthesiologist) and his/her associates to provide anesthesiology services for me including the performance of any additional procedures that in his/her judgment may be advisable and medically necessary for my well being.

Anesthesia involves the use of medications and procedures. Anesthetic medications may, on occasion, cause unusual or unexpected reactions in some patients. In addition, ones' physical condition or health may influence the actions of anesthesia medication. Anesthetic procedures are often necessary to provide you with a safer anesthetic and recovery from surgery. Examples of anesthetic procedures include placing catheters into arteries and veins or placing tubes/probes down the esophagus. These additional procedures allow for more intensive monitoring of your vital functions and are intended to provide your anesthesiologist with as much information as necessary to provide you with sound medical care. All reasonable precautions will be taken; however, unforeseen reactions or complications can occur.

I understand and accept that certain hazards and risks, although uncommon, are inherent with anesthesiology services. Post anesthetic nausea and vomiting, headache, inflammation of a vein(s), recall of sound/noise/speech by others, sore throat, and injury to mouth/lips/vocal cords/eyes are examples of some potential complications. Even though steps are taken to protect teeth/dentures/bridgework there is no guarantee against accidental damage, even for normal teeth.

Anesthesia may also result in more serious heart, lung, nerve, or muscle dysfunction. Although very rare, there is always a remote risk of paralysis, brain damage, heart attack, or death with the administration of anesthetics.

Regional anesthetics such as spinals, epidurals, and nerve blocks can have other potential complications such as backaches, headaches, and/or nerve injuries. Nerve injuries can result in persistent pain, numbness and/or weakness.

There is no guarantee against the development of complications with the administration of any type of anesthesia or the performance of anesthetic procedures.

I understand that conditions may develop that may require a change in the type of anesthesia initially decided upon by me and my anesthesiologist and that additional procedures may become necessary during the course of an anesthetic. I therefore authorize, in advance, modifications or extension of this consent as medical judgment may indicate.

The nature of the proposed anesthesiology services and available alternatives have been explained to me. No warranty or guarantee has been given to me. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I, therefore, consent for anesthesiology services.

X _____ 8/31/22 0745

Signature Patient/Parent/Conservator/Guardian Date/Time

_____ 8/31/22 0745

Signature Witness Date/Time

CONS-11 (12/15/05)

Sequoia Surgical Pavilion

In Partnership with Physician Owners

DISTRIBUTION: WHITE: PATIENT CHART YELLOW: PATIENT COPY

CONSENT FOR ANESTHESIOLOGY SERVICE

Rev.8/2017

PATIENT LABEL

SCHLEGEL, NIKOLAI
ID / Visit: 97281 / 1
DOB: 9/30/1970
Phys: KOU, JOSEPH
DOS: 8/31/2022
Gender: M
Age: 51

Autorizo e instruyo al Dr. _____, (anestesiólogo) y a sus asociados, proporicionarme los servicios de anestesiología, incluyendo la realización de caulquier procedimiento que, en su cirterio, sea aconsejable y méicamente necesario para mi bienestar.

La anestesia involucra el uso de medicamentos y procedimientos. En ocasiones, medicamentos de anestesia, pueden causar, en algunos pacientes, reacciones inusuales e inesperadas. Adicionalmente, el estado físico o salud del paciente pueden influenciar las acciones de la medicación de anestesia. Los procedimientos anestésicos son frecuentemente necesarios para proporcionarle una anestesia más segura y recuperación de su operación. Ejemplos de procedimientos anestésicos incluyen, la colocación de catéteres dentro las arterias y venas o colocació de tubos o sondas por el esófago. Estos procedimientos adicionales, permiten un control más intensivo de sus funciones vitales y están ahí para proporcionar a su anestesiólogo con la mayor cantidad de información necesaria para proporcionarte a usted la mejor atención médica. Se tomarán todas las precauciones razonables; sin embargo, pueden ocurrir reacciones o complicaciones impredecibles.

Entiendo y acepto que existen ciertos peligros y riesgos que, aunque no muy comunes, son inherentes a los servicios de anestesiología. Nauseas y vómitos, dolor de cabeza, inflamación de la vena o venas, volver a escuchar sonidos, ruidos, habla por otros, dolor de garganta y lesiones en la boca, labios cuerdas vocales, u ojos, son un ejemplo de algunas posibles complicaciones. No obstante que se toman pasos para proteger los dientes, placas dentales, prótesis dental, no hay ninguna garantía contra daños accidentales, incluso en una dentaduara normal.

La anestesia puede resultar en la disfunción del corazón, pulmones, nervios, o musculos. Aunque muy raro, siempre existe un riesgo remoto de parálisis, daño cerebral, ataque al corazón, o muerte con la administración de anestésicos.

Los anestésicos locales como ser a la espina dorsal, epidurales y bloqueo de nervios, pueden tener otras complicaciones como ser, dolores de espalda, dolores de cabeza, y/o lesiones en los nervios. Las lesiones en los nervios pueden resultar en dolor persistente, entumecimiento y/o debilidad.

No existe ninquna garantía contra el desarrollo de complicaciones debido a la administración de caulquier tipo de anestesia o el comportamiento de procedimientos anestésicos.

Entiendo que se pueden desarroilar condiciones que puedan requerir un cambio en el tipo de anestesia inicialmente decidada por mí y mi anestesiólogo y que puede requerir la necesidad de procedimientos adicionales, durante el curso de una anestésico. Por lo tanto, autorizo por adelantado, modificaciones o extensiones a esta autoización, de acuerdo a lo que el criterio médico pueda dictar.

Me han explicado la naturaleza del servicio de anestesiología propuesto y las alternativas disponibles. No se me ha otorado, ninguna seguridad o garantía. He tenido la oportunidad de hacer preguntas y mis preguntas han sido respondidas a mi entera satisfacción. Por lo tanto, doy mi consentimiento a los servicios de anestesiología.

_____

Firma Paciente / Familiar / Conservador / Apoderado Fecha/Hora

_____

Firma Testigo Fecha/Hora

CONS-11 (12/15/05)

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DISTRIBUTION: WHITE: PATIENT CHART YELLOW: PATIENT COPY

CONSENTIMIENTO PARA SERVICÍOS DE ANESTESIOLOGIA

PATIENT LABEL

Sequoia
Surgical Pavilion

In Partnership with Physician Owners

SCHLEGEL, NIKOLAI
ID / Visit: 97281 / 1
DOB: 9/30/1970
Phys: KOU, JOSEPH
DOS: 8/31/2022
Gender: M
Age: 51

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I hereby assign to and authorize payment directly to the facility named above (the "facility") of all benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility.

A photostatic copy of this agreement shall be considered effective and valid as the original.

I irrevocably agree that the facility may disclose, to the extent allowed by law, my medical and financial record to (a) any affiliate of the facility specifically including NATIONAL SURGICAL HOSPITALS and its employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, or any person or entity responsible for all or part of the facility's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Health Care Financing Administration, any other governmental or accrediting agency, or their agents or employees.

All facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payor. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney, patient monitoring agency or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the facility files for reimbursement from my insurer or other payor as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amounts when and as due.

The undersigned authorizes to the extent necessary for the facility to obtain reimbursement for services rendered.

Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

Nikolai Schlegel 8/31/22

PATIENT **DATE** | **GUARANTOR** **DATE**

8/31/22

WITNESS **DATE**

ADVANCE NOTIFICATION

I received an Advanced Notification form which provided me with my patient rights, information regarding the grievance process, physician ownership, and advanced directives, prior to consenting for surgery.

PATIENT/AUTHORIZED AUTHORITY Nikolai Schlegel **DATE:** 8/31/22 **TIME:** 7:05 AM

ADVANCE DIRECTIVES/LIVING WILL/HEALTH CARE PROXY

I understand I have the right to make choices regarding life-sustaining treatment (including resuscitative-measures).

- ☐ Yes, I have an Advance Directive/Living Will/Health Care Proxy. The facility has explained to me their policy regarding the honoring of this document (see Advance Notification form) and I agree to proceed with the proposed procedure as scheduled.
  - ☐ I have provided a copy to the facility
  - ☐ My directive is on file at
- ☒ I do not have an Advance Directive/Living Will/Health Care Proxy
- ☐ I wish to have information on how I can obtain an Advance Directive/Living Will/Health Care Proxy.

For information on how to obtain an Advanced Directive/Living Will/Health Care Proxy visit the following website:
http://www.calhospital.org/resource/advance-health-care-directive

PATIENT/AUTHORIZED AUTHORITY Nikolai Schlegel **DATE:** 8/31/22 **TIME:** 7:05 AM

Rev.8/2017

White Copy - Medical Records **Yellow Copy** - Patient Copy

Postoperative Instructions for Peripheral Nerve Block

UPPER EXTREMITY

What is a peripheral nerve block?
A peripheral nerve block is a procedure in which a long-acting local anesthetic is placed around a nerve or group of nerves that go to either the arm or the leg. The local anesthetic "blocks" the nerves that carry the pain signals. The purpose of the nerve block is to provide effective pain relief after surgery.

IMPORTANT:
The local anesthetic also blocks the nerves that move the muscles of the limb as well as the nerves that carry the "touch" sensation. So, to varying degrees *your arm will be numb and unable to move.* You must use extra care to **protect your arm against injury** during the time that the nerve block is functioning. Also, it's not uncommon for the skin numbness to last several hours longer than the pain relief. If you have numbness or weakness that lasts for more than 6 hours *after the pain relief has worn off,* you should contact your surgeon.

You have received...

☐ **Interscalene Nerve Block**
This block is performed for pain relief after shoulder or upper arm surgery. The typical duration of the block is 8 to 14 hours, with an average of about 10 hours. Your entire arm may be numb, although frequently the forearm and hand are spared. Other nearby nerves are also blocked and as a result there are two common side effects – a droopy eyelid on the blocked side and a hoarse or raspy voice. These side effects wear off when the nerve block wears off. An *occasional* patient may feel that their breathing has been affected – a sensation that you'd like to breathe just a little bit deeper. This sensation is usually relieved simply by sitting completely upright, and will also disappear when the nerve block wears off. Resting in a big chair with a footstool or in a recliner may be comfortable and also may provide good support for your arm.

☐ **Axillary Nerve Block or Infraclavicular Nerve Block**
This block is performed for pain relief after surgery of the elbow, forearm, wrist or hand. The typical duration of this block is 6 to 14 hours, with an average of about 10 hours. With this block, the arm frequently is densely numb and it is important to protect it from pressure or injury. Wear your sling and use pillows to keep the operative area above the level of your heart.

Pain Management for ALL Nerve Blocks
It is easier to keep control of your pain if you "stay ahead of it", rather than play catch up. We typically recommend that you begin taking your pain medication *before the nerve block wears off.* Using the average block duration listed in your instructions above, take your first pain medication an hour or two before you expect the block to wear off. Certainly, take your pain medication sooner if you begin to feel any pain, discomfort or if you sense the numbness wearing off. If the medication prescribed for you is not effective in managing the pain, contact your surgeon.

EXPAREL: If this medication was used, you may experience pain relief and numbness for up to 72 hours, with an average of 40 hours. You might hold off on pain medicine until you feel it is needed.

Other instructions:-

_____

_____

Postoperative Instructions for Peripheral Nerve Block

LOWER EXTREMITY

What is a peripheral nerve block?
A peripheral nerve block is a procedure in which a long-acting local anesthetic is placed around a nerve or group of nerves that go to either the arm or the leg. The local anesthetic "blocks" the nerves that carry the pain signals. The purpose of the nerve block is to provide effective pain relief after surgery.

IMPORTANT:
The local anesthetic also blocks the nerves that move the muscles of the limb as well as the nerves that carry the "touch" sensation. So, to varying degrees *your leg will be numb and unable to move.* You must use extra care to **protect your leg against injury** during the time that the nerve block is functioning. Also, it's not uncommon for the skin numbness to last several hours longer than the pain relief. If you have numbness or weakness that lasts for more than 6 hours *after the pain relief has worn off,* you should contact your surgeon.

You have received...

☐ **Femoral Nerve Block or Adductor Canal Block**
This block is used to provide pain relief after surgery on the knee or thigh. It is frequently used for ACL reconstruction. The typical duration of this block is 6 to 14 hours, with an average of about 10 hours. The pain relief provided by this block covers most, but not the entire knee. It does not cover pain in the back of the knee. If you have pain in the back of your knee, it is because the pain is coming from an area outside of the territory of this nerve block (not because there is something wrong with the block). You should take your pain medication for this pain, but be prepared for an increase in overall knee pain when the block wears off.

☐ **Sciatic Nerve Block, most frequently performed as a Popliteal (back of knee) Nerve Block**
This block is performed to provide pain relief after surgery on the lower leg, ankle or foot. It is the longest lasting nerve block that we perform. It, typically, provides pain relief for at least 12 hours, but can last up to 16 hours, or even 24 hours. The nerve that is blocked doesn't cover a small area over the inner side of the ankle. If you have pain there, you may need to take some pain medication, even before the block has worn off.

☐ **Ankle Nerve Block**
This nerve block is a block of several nerves around the ankle as they enter the foot. The typical duration of this block is about 6 to 10 hours.

Pain Management for ALL Nerve Blocks
It is easier to keep control of your pain if you "stay ahead of it", rather than play catch up. We typically recommend that you begin taking your pain medication *before the nerve block wears off.* Using the average block duration listed in your instructions above, take your first pain medication an hour or two before you expect the block to wear off. Certainly, take your pain medication sooner if you begin to feel any pain, discomfort or if you sense the numbness wearing off. If the medication prescribed for you is not effective in managing the pain, contact your surgeon.

EXPAREL: If this medication was used, you may experience pain relief and numbness for up to 72 hours, with an average of 40 hours. You might hold off on pain medicine until you feel it is needed.

Other instructions:-

_____

_____

- Constipation is not unusual after surgery. It is commonly due to immobility and the use of narcotic medications. Fiber supplements or a stool softener such as Colace should be used to treat this.

PAIN MEDICATION (take as needed):

- ~~**Motrin/Ibuprofen** 400-600mg every 4-6 hours~~
  - **or** Aleve/Naproxen 250-500mg every 12 hours
- ~~**Percocet** (Oxycodone/Acetaminophen) 1-2 tablets every 4-6 hours~~
- ✓ **Norco** (Hydrocodone/Acetaminophen) 1-2 tablets every 4-6 hours
- ~~**Dilaudid** (Hydromorphone) **SEVERE BREAKTHROUGH PAIN ONLY** 1 tablet 4-6 hours~~
- ~~**Anti-Nausea Medication: Zofran** (Ondansetron) 1 tablet dissolved under tongue every 6 hours, as needed~~

OTHER MEDICATION:

- ~~**Aspirin** 325mg tablet DAILY for 21 days after surgery to lower the risk of thromboembolic event (blood clot, DVT, PE)~~
  - Begin the day AFTER surgery
- ✓ **Antibiotics:** Take first dose of **Keflex** (Cephalexin) _____ AM / PM

✓ Xarelto · Restart tomorrow morning

Return appointment 10-14 days after surgery

Sequoia Surgical Pavilion

POST OPERATIVE FOOT/ANKLE SURGERY INSTRUCTIONS

Joseph Kou, MD (925) 939-8585

DURING FIRST 24 HOURS:

- You should have a responsible adult stay with you all day and night
- Rest. Do not do anything that requires balance, judgement or coordination such as driving a car or using household appliances
- Do not make important decisions or sign notarized documents
- Start with a liquid or soft diet and advance as tolerated. Do not consume any alcohol for 24 hours or while taking pain medication
- You may experience any of the following symptoms: drowsiness, nausea, muscle soreness, throat irritation, and/or mild tenderness at your IV site
    - If you experience nausea associated with pain medication you may take Benadryl (25-50mg tablet) 15 minutes prior to administering pain medication

PLEASE NOTIFY YOUR DOCTOR IF YOU ARE EXPERIENCING:

- Unexpected or uncontrolled pain
- Uncontrolled nausea
- Unexpected bleeding from surgical site
- Fever over 102^0 or skin rash
- Inability to empty your bladder within 6 hours
- Chest or calf pain
- Shortness of breath

IF YOU ARE UNABLE TO CONTACT YOUR DOCTOR OR SURGERY CENTER, YOU SHOULD GO TO THE NEAREST EMERGENCY ROOM

OTHER POST-OP INSTRUCTIONS:

- See Medication Reconciliation form for instructions on resuming your home medications
- Do not remove dressing, but you may loosen up the dressing if it feels too tight
- Keep dressing / cast/ splint clean and dry
- Keep your leg elevated as much as possible, above the level of your heart
- Use ice packs to control pain and swelling if you do not have a cast on
- Strict non-weight bearing on the operative extremity. Use an assistive device, i.e. crutches, scooter, walker, etc. until further instructions at post-op visit
- Swelling and discoloration is normal, particularly if the extremity is not elevated
- If an anesthetic block was performed, it is normal for the extremity to feel numb until the effects wear off. This can be as long as 36 hours. If the toes are still pink and warm, there is no reason to be concerned about the numbness during this time period
- If the dressing becomes saturated with blood, make sure that the extremity is being elevated as much as possible. If you continue to bleed despite elevation, please notify the doctor

POST OPERATIVE PHONE CALL

PROCEDURE		SPOKE WITH ❑ Family/Significant Other ❑ Patient ❑ Answering Machine ❑ Parent Name _____ ❑ Unable to reach _____
DATE OF 1ST CALL	DATE OF 2ND CALL	TELEPHONE NUMBER ( ) ❑ No telephone
INTRA-OP/PACU PERTINENT INFORMATION ❑ NO		
TYPE OF BLOCK		ANESTHESIOLOGIST
START / WORE OFF / DURATION		SIGNATURE RN

1. Since your surgery have you had any of the following problems:
   ❑ Fever > 100 ❑ Urinary retention requiring treatment ❑ Constipation
   ❑ Patient is instructed to call physician

2. Since your surgery have you been satisfied with your pain control? ❑ NO ❑ YES
   When did you take your first pain pill? _____ ❑ NA
   When did you first notice the block wearing off? _____ ❑ NA
   ❑ Patient is instructed to call physician
   Comments/Intervention: _____

3. Did you have any problems at home from your anesthetic? ❑ NO ❑ YES
   If yes: ❑ N/V requiring further treatment ❑ Sore throat/hoarseness > 24 hrs ❑ Other
   ❑ Patient is instructed to call physician
   Comments/Intervention: _____

4. Did you understand your discharge instructions? ❑ NO ❑ YES
   If no: ❑ Didn't understand ❑ Didn't receive ❑ Has further questions now ❑ Other
   Comments/Intervention: _____

5. Were you satisfied with the care that you and your family received? ❑ NO ❑ YES
   If no: ❑ Felt rushed ❑ Lack of privacy ❑ Long wait ❑ Staff/pt. interaction
   ❑ Experienced uncontrolled pain ❑ Other
   Comments/Intervention: _____

6. Was there anything we could have done to make you more comfortable? ❑ NO ❑ YES
   Comments/Intervention: _____

7. Is there anyone you would like to recognize? ❑ NO ❑ YES
   Comments/Intervention: _____

Sequoia Surgical Pavilion
In Partnership with Physician Owners
2405 Shadelands Drive, Suite 200, Walnut Creek, CA 94598 • 925.935.6700

DISCHARGE INSTRUCTIONS

You have just experienced "Ambulatory Surgery." We hope your visit was a pleasant one. Since you are continuing your recovery in the comfort of your home, here are some key points to keep in mind during your recovery...

EATING

1. Begin with clear liquids. Eat light food for the first few hours after surgery (Jell-O, soup, crackers).
2. Progress to regular foods as tolerated. Avoid heavy, greasy and spicy foods for the first 24 hours.
3. NO alcoholic beverages for 24 hours, and for as a long as you are taking prescription pain medication.

ACTIVITY

1. You may feel dizzy, move slowly at first.
2. Limit your activities for the first 24 hours. Be sure to rest the day of your surgery.
3. Have a responsible adult stay with you, to assist in your care for the first 24 hours.
4. Do not make any important personal or business decisions or sign any legal documents for 24 hours.
5. Do not drive or operate heavy machinery for 24 hours.
6. Do not engage in heavy work or athletic activities until your surgeon's approval.

PAIN

1. Fill your pain prescriptions and take as directed.
2. Elevate your surgical site above the level of your heart.
3. Apply ice to your surgical site for 15-20 minutes, every hour, if not contraindicated by your surgeon.
4. If your pain is not relieved by any of the above items, please call your surgeon.

NAUSEA & VOMITING

1. Nausea and vomiting can occasionally occur after anesthesia.
2. Remain on a clear liquid diet until the nausea goes away.
3. If the nausea or vomiting does not go away, please call your surgeon.

SCHLEGEL, NIKOLAI
ID / Visit: 97281 / 1 Gender: M
DOB: 9/30/1970 Age: 51
Phys: KOU, JOSEPH
DOS: 8/31/2022

BLEEDING

1. Observe your bandage for any bleeding or drainage.
2. If bleeding is noted, elevate the site, apply pressure for ten minutes and call your surgeon.
3. If the bleeding does not stop, go to your nearest emergency room.

SIGNS & SYMPTOMS OF INFECTION

1. Temperature of 100.5°, swelling, heat, drainage or redness around the surgical site.
2. If you have any signs or symptoms of infection, please call your surgeon.

If you are having excessive or persistent pain, nausea, swelling, bleeding, signs of infection, any other problems regarding your surgery or if you feel there is anything abnormal taking place, please contact your surgeon. If you are unable to contact your surgeon, seek help from the nearest emergency room.

Last oral pain medication given at _____ am/pm, next dose not before _____ am/pm/anytime

Follow up appointment with your surgeon: As scheduled

Surgeon: Dr Kou Phone: (925) 939-8585

Other instructions: Start Xarelto tomorrow morning

Instructions reviewed with care provider: Stephanie Relationship: Wife

Nurse Signature: _____ (858) 472-1260

Sequoia Surgical Pavilion

PRIVACY NOTICE

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

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The SEQUOIA SURGICAL PAVILION may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless theSEQUOIA SURGICAL PAVILION has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. **Treatment**. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the SEQUOIA SURGICAL PAVILION with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. **Payment**. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. **Operations**. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of all or a portion of the SEQUOIA SURGICAL PAVILION and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. **Other Uses and Disclosures**.As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes:

1. To remind you of your surgery date.

2. We may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that we provide and that may be of interest to you.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. **When Legally Required or Permitted**. We will disclose your protected health information when we are required or permitted to do so by any federal, state or local law. One situation in which we may disclose your protected health information is in the instance of a breach involving your protected health information, to notify you, law enforcement and regulatory authorities, as necessary, of the situation, and others as appropriate to resolve the situation.

B. **When There Are Risks to Public Health**. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. **To Report Suspected Abuse, Neglect Or Domestic Violence**. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. **To Conduct Health Oversight Activities**. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. **In Connection With Judicial And Administrative Proceedings**. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. **For Law Enforcement Purposes**. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the SEQUOIA SURGICAL PAVILION has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. **To Coroners, Funeral Directors, and for Organ Donation**. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the

coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Once you have been dead for 50 years (or such other period as specified by law), we may use and disclose your health information without regard to the restrictions set forth in this notice. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. **For Research Purposes**. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information. Under certain circumstances, your information may also be disclosed without your authorization to researchers preparing to conduct a research project or for research on decedents or to researchers pursuant to a written data use agreement.

I. **In the Event of a Serious Threat to Health or Safety**. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. **For Specified Government Functions**. In certain circumstances, federal regulations authorize the SEQUOIA SURGICAL PAVILION to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. **For Worker's Compensation**. The SEQUOIA SURGICAL PAVILION may release your health information to comply with worker's compensation laws or similar programs.

L. **Business Associates.** We may contract with one or more business associates through the course of our operations. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. We required that our business associates sign a business associate agreement and agree to safeguard the privacy and security of your health information.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization. Examples of disclosures that require your authorization are:

A. **Marketing**. Except as otherwise permitted by law, we will not use or disclose your health information for marketing purposes without your written authorization. However, in order to better serve you, we may communicate with you about refill reminders and alternative products. Should you inquire about a particular

product-specific good or service, we may also provide you with informational materials. We may also, at times, send you informational materials about a particular product or service that may be helpful for your treatment.

B. **No Sale of Your Health Information.** We will not sell your health information to a third party without your prior written authorization.

V. Your Rights

You have the following rights regarding your health information:

A. **The right to inspect and copy your protected health information.** You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the SEQUOIA SURGICAL PAVILION use for making decisions about you.

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

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. **The right to request a restriction on uses and disclosures of your protected health information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

If you request that the SEQUOIA SURGICAL PAVILION not disclose your protected health information to your health plan for the purposes of payment or healthcare operations (but not treatment), and if you are paying for your treatment out of pocket in full, then the SEQUOIA SURGICAL PAVILION must honor your requested restriction. Otherwise, the SEQUOIA SURGICAL PAVILION is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the SEQUOIA SURGICAL PAVILION does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. **The right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. **The right to request amendments to your protected health information.** You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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 with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. **The right to receive an accounting.** You have the right to request an accounting of certain disclosures of your protected health information made by the SEQUOIA SURGICAL PAVILION. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for anSEQUOIA SURGICAL PAVILION directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. After January 1, 2014 (or a later date as permitted by HIPAA), the list of disclosures will include disclosures made for treatment, payment or health care operations using our electronic health record (if we have one for you). We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. **The right to obtain a paper copy of this notice.** Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The SEQUOIA SURGICAL PAVILION is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the SEQUOIA SURGICAL PAVILION changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact at your next visit. In the event there has been a breach of your unsecured protected health information, we will notify you.

VII. Complaints

You have the right to express complaints to the SEQUOIA SURGICAL PAVILION and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the SEQUOIA SURGICAL PAVILION by contacting the SEQUOIA SURGICAL PAVILION's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The SEQUOIA SURGICAL PAVILION's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by the SEQUOIA SURGICAL PAVILION you may submit a complaint to our Privacy Officer by sending it to:

Privacy Officer **Roxanne Womack**
SVP, Chief Compliance Officer
Surgery Partners
310 Seven Springs Way
Brentwood, TN 37027
Office: 615-234-5967
E-mail: Compliance@surgerypartners.com

IX. Effective Date

This Notice is effective April 14, 2003, with revisions effective February 17, 2010, September 2013, and June 28, 2019