

# Fashion Island

SURGERY CENTER

WELCOME,

Welcome to Fashion Island Surgery Center, where our goal is to provide a safe and friendly environment, ensuring you have a positive experience as we work with your physician and their staff to coordinate your care with us.

Your physician is an integral part of Fashion Island Surgery Center, which is why they have chosen our center as the facility to meet your health care needs. This packet contains information to make you aware of a few things that will help you better understand what you can expect from your experience with us.

Below is a list of items you will need to bring with you on the day of surgery. Additionally, we have listed some phone calls you can be expecting related to your upcoming procedure/surgery at Fashion Island Surgery Center.

Items to Bring with You on The Day of Surgery	Phone Calls to Expect Prior to Your Procedure
<ul style="list-style-type: none"><li>• Paperwork your physician has asked you to complete in advance of your procedure (if applicable)</li><li>• Responsible adult (18 years or older) to transport you home after your procedure</li><li>• Valid Government Issued Photo ID</li><li>• Method of Payment</li><li>• Insurance Card (if applicable)</li></ul>	<ul style="list-style-type: none"><li>• Pre-Admission Nurse</li><li>• Insurance Verification (if applicable)</li><li>• <b>Please be sure to return any missed phone calls or voice messages</b></li></ul> <p><i>*Please leave your valuables and jewelry at home*</i></p>

Included in your packet:

- Welcome letter - Patient Information Sheet
- Fashion Island Surgery Center's Policy on Advance Directives
- Patient Rights, Responsibilities, and Notice of Physician Financial Interest/Ownership
- Notice of Privacy Practices
- Pre-Anesthesia Surgery Questionnaire & Site Verification Form
- Current Medications Form

Sincerely,

The Fashion Island Surgery Center Team

Fashion Island Surgery Center  
1441 Avocado Ave Suite 100  
Newport Beach, CA 92660  
(949) 209-5960

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## Our Policy on Advanced Directives

Fashion Island Surgery Center honors and respects the patient's right to having Advance Directives and/or a Living Will and acknowledges that all patients have the right to participate in their own healthcare decisions and to make Advance Directives or to execute powers of attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions.

It is the consensus of the Fashion Island Surgery Center management, physicians, and staff that, because individuals having surgery in this facility are generally of good health and the procedures are considered elective, if untoward medical events should occur, life sustaining procedures would be initiated in this facility. We would then follow protocol to transfer to a facility, where the patient's Advanced Directives could be considered, for appropriate care and treatment.

If requested, information about Advanced Directives will be given to the patient at the time of Admission. Patients with advanced directives are responsible for informing their physicians, as well as the facility and providing a copy.

In the event a patient has an Advanced Directive and presents a copy, it shall be placed in the patient's medical record at the time of admission and shall be sent with the patient in the event of a transfer to a hospital. The presence of an advance directive shall be clearly documented on the facility documentation form and shall be communicated to staff participating in the patient's care.

Advance Directive information shall be updated at every patient visit.

Additional information about Advanced Directives can be obtained from the California Advance Directive Registry at [www.sos.ca.gov/registries/advance-health-care-directive-registry](http://www.sos.ca.gov/registries/advance-health-care-directive-registry).

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## **PATIENT'S RIGHTS**

### **AS A PATIENT, YOU HAVE THE RIGHT TO:**

1. Considerate, respectful, and dignified care, and respect for personal values, beliefs, and preferences.
2. Have a family member (or other representative of his/her choosing) and his/her own physician notified promptly of his/her admission to the facility.
3. Know the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and non-physicians who will see him/her.
4. Know if your physician fails to have or has malpractice insurance that is either expired and/or lapsed.
5. Expect the center to disclose, when applicable, physician financial interests or ownership in the center.
6. Receive information about health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms that can be understood.
7. Make decisions regarding medical care and receive as much information about any proposed treatment or procedure in order to give informed consent or refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
8. To be advised if the facility/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. The patient has the right to refuse to participate in such research projects.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions.
10. Formulate advance directives regarding his/her healthcare, and to have facility staff and practitioners who provides care in the facility comply with these directives (to the extent provided by state laws and regulations).
11. Know this center's policy regarding advance directives and how to obtain more information from the State of California regarding advance directives and how to obtain further information.
12. Have personal privacy respected. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly.
13. Confidential treatment of all communications and records pertaining to the care and visit. The patient will receive a separate "Notice of Privacy Practices" that explains his/her rights in detail and how we may use and disclosure of protected health information.
14. Access information contained in your records within a reasonable time frame, except in certain circumstances specified by law.
15. Receive care in a safe setting, free from mental, physical, sexual, or verbal abuse and neglect, exploitation, or retaliation by staff. The patient has the right to access protective services and advocacy services including notifying government agencies of neglect or abuse.
16. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience, or retaliation by staff.
17. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
18. Be informed by the physician, or a delegate of the physician, of continuing healthcare requirements and options following discharge from the facility.
19. Examine and receive an explanation of the facility's bill regardless of the source of payment.

20. Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, gender identify, gender expression, educational background, economic status, or the source of payment for care. Fashion Island Surgery Center does not exclude, deny benefits to, or otherwise discriminate against any person on these bases in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Fashion Island Surgery Center directly or through a contractor or any other entity with which Fashion Island Surgery Center arranges to carry out its programs and activities. Inquiries, grievances, or complaints related to this non-discrimination policy may be directed to the:

Administrator  
Fashion Island Surgery Center  
1441 Avocado Avenue, Suite 100  
Newport Beach, CA 92660  
(949) 209-5960

21. Voice or file a grievance regarding treatment or care that is, or fails to be, furnished without fear of reprisal. If you want to file a grievance you may do so by writing or calling the:

Administrator  
Fashion Island Surgery Center  
1441 Avocado Avenue, Suite 100  
Newport Beach, CA 92660  
(949) 209-5960

22. File complaint with the state Department of Public Health Service by writing or calling:

Department of Public Health  
681 South Parker St. Suite #200  
Orange, CA 92868  
(714) 567-2906 (800) 236-9747

23. File a complaint with AAAHC:

AAAHC  
5250 Old Orchard Road, Suite 200  
Skokie, Illinois 60077 (847) 853-6060

24. File a complaint with Medical Board of California:

Medical Board of California  
2005 Evergreen Street, Suite 1200  
Sacramento, CA 95815  
Email: [webmaster@mbc.ca.gov](mailto:webmaster@mbc.ca.gov)  
Phone: (800) 633-2322

25. File a complaint through the Medicare Beneficiary Ombudsman via their website or by calling:

1-800-896-4042

<https://www.medicare.gov/claims-appeals/your-medicare-rights/get-help-with-your-rights-protections>

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## **NOTIFICATION OF PATIENT'S RESPONSIBILITIES AND PHYSICIAN OWNERSHIP**

### **AS A PATIENT, YOU ARE RESPONSIBLE:**

1. To provide complete and accurate information to the best of your ability regarding your health, any medications, including over the counter products and dietary supplements, and any allergies or sensitivities.
2. To provide complete information concerning your present complaints, past medical history, and other matters relating to your health.
3. To inform us if you do not clearly comprehend the course of your medical treatment and what is expected of you.
4. To follow the treatment plan established by your physician, including instructions from nurses and other healthcare professionals as they carry out your physicians' orders.
5. For your actions, should you refuse treatment or not follow your physician's orders.
6. To accept personal financial responsibility for any charges not covered by your insurance and to assure the financial obligations of your care are fulfilled as promptly as possible.
7. To be considerate of the rights of other patients and to be respectful of all healthcare professionals and staff.
8. For your valuables and personal property, and for respecting the property of others.
9. To provide a copy of your Advance Directive upon arrival.
10. Provide a responsible adult to transport you to home from the facility and remain with you for 24 hours if required by your provider.
11. If you do not understand these rights and responsibilities, or if you have additional questions, please ask to speak with the Administrator for further explanation.

### **PHYSICIAN FINANCIAL INTEREST AND OWNERSHIP**

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

### **THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER:**

Dr. Daniel Kim M.D.   Dr. Steven Ip M.D.   Dr. Michael Lee M.D.

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## NOTICE OF PRIVACY PRACTICES

### **Your Information. Your Rights. Our Responsibilities.**

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**

#### **Your Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### **Your Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

#### **Our Uses and Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

#### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

##### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

##### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

##### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

##### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

## Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

## Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

## Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

## File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

#### Treat you

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

### **Do research**

We can use or share your information for health research.

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.  
For more information see:  
[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).



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## PRE-ANESTHESIA SURGERY QUESTIONNAIRE

Name of your primary care physician:	Physician Phone:
<input type="checkbox"/> I do not have a primary care physician:	Height:                      Weight:                      lbs / kg                      BMI:

Please mark yes or no to the following questions and add explanations or details as needed.	YES	NO
1. Are you allergic to anything? (Please list):		
2. Have you ever had any problems with blood pressure, previous heart disease, palpitations, or angina?  If yes, please explain:		
3. Have you had an EKG in the past? If yes, where? When?		
4. Have you or any blood relative had an unusual reaction to anesthesia or malignant hyperthermia?		
5. Have you had any (Circle) breathing problems, asthma, hay fever, chronic bronchitis, emphysema, or shortness of breath?		
6. Have you had any (Circle) seizures, convulsions, migraine headaches, fainting spells or stroke?		
7. Have you had (Circle) Jaundice , hepatitis, liver disease or blood transfusion reactions?		
8. Do you have (Circle) diabetes, hypoglycemia, or thyroid problems?		
9. Do you have kidney problems?		
10. Have you had (Circle) a cold, sore throat, or flu in the last two weeks?		
11. Any recent exposure to Covid-19 <input type="checkbox"/> Yes <input type="checkbox"/> No / Covid test within the last 72 hours <input type="checkbox"/> Yes <input type="checkbox"/> No / Vaccinated <input type="checkbox"/> Yes <input type="checkbox"/> No	/	/
12. Any recent exposure to tuberculosis?		
13. Within the last two weeks have you had any exposure to chicken pox, mumps, measles (rubeola), German measles (rubella)?		
14. Do you have any (Circle) physical disabilities, back pain, arthritis, or bursitis?		
15. Do you have sleep apnea? C-PAP? Sleeping disorders? Snoring?		
16. All other medical conditions? List:		
17. Do you have any implants? (Cardiac, Cosmetic, Orthopedic) List:		
18. Have you ever had motion sickness?		
19. Do you smoke/vape? If yes, what? How much/often?		
20. Do you drink alcoholic beverages? Do you use recreational drugs? If yes, what? How much/often?		
21. Do you have (Circle) any loose teeth, dentures, permanent or removable bridges or front capped teeth?		
22. Do you wear contacts?		
23. Do you have any difficulty opening your mouth?		
24. Within the last year have you had cortisone or steroids?		
25. Within the last two weeks have you taken ( Circle ) a tranquilizer, diet pills or herbal medications?		
26. Have you taken any medication today? List:		
27. Do you use aspirin, ibuprofen (Motrin), Advil, Aleve, Naproxen or anaprox? Last date taken?		
28. Do you use blood thinners (Heparin, Lovenox, Coumadin, etc.)? Last date taken?		
29. Do you have bleeding tendencies?		
30. Could you be pregnant at this time? Date of last menstrual period:		
31. Circle pain medications you have taken: Tylenol Percocet Codeine Darvocet Vicodin Other:		

# Fashion Island

## SURGERY CENTER

Please describe **in your own words** what procedure you're having done today: \_\_\_\_\_

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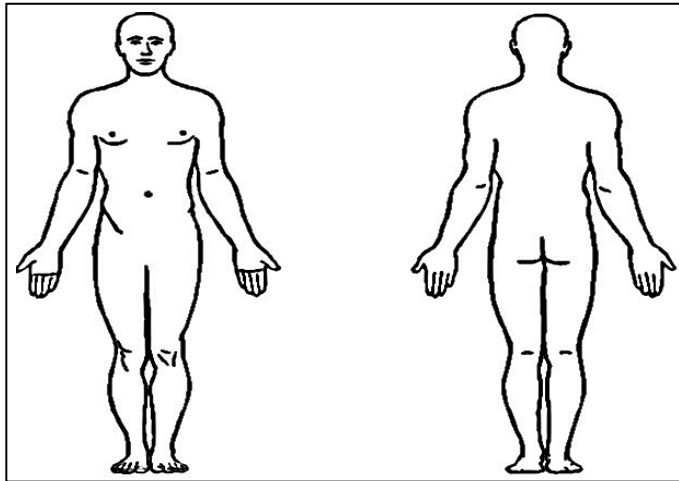


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**Indicate surgery site with an  
circle/mark on the figure**



Previous Surgeries	Year Done	Type of Anesthesia (General, MAC, Local)	Complications (Example: Infection, Nausea)

Patient/Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed by Pre-Op RN: \_\_\_\_\_ OR RN: \_\_\_\_\_

Date: \_\_\_\_\_

