LOS ALAMITOS
SURGERY CENTER

COVID-19 Screening

1. Have you been outside of the country in the last 14 days?
   Yes ☐ No ☐

2. Has anyone you've been in contact with been outside of the country in the last 14 days?
   Yes ☐ No ☐

3. Do you have a fever, cough, or shortness of breath?
   Yes ☐ No ☐

4. Does anyone you live with have a fever, cough, or shortness of breath?
   Yes ☐ No ☐

5. Have you travelled by plane, train, or bus in the last 14 days?
   Yes ☐ No ☐

6. Have you previously tested positive for COVID-19?
   Yes ☐ No ☐

   If yes, what was the date you tested positive? _________/_________/_________

7. Are you fully vaccinated? You are ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine
   Yes ☐ No ☐

8. Have you received a booster shot for Covid 19?
   Yes ☐ No ☐

If you have answered "Yes" to any of the questions 1- 6, please put a mask on now, and inform the staff immediately.

Temperature:

____

Signature of Patient, Parent or Guardian Date and Time signed

____

Witness Date and Time signed

LOS ALAMITOS
SURGERY CENTER

ANESTHESIA QUESTIONNAIRE

Height ___________________ Weight _________________

Do you have any **MEDICATION ALLERGIES?** Yes No
If YES please list
____
____

Do you have any FOOD **ALLERGIES?** Yes No
If YES please list
____
____

Are you allergic to Latex? Yes No

List any other hospitalizations with reasons and approximate dates and any chronic illness(es) or condition(s):
____
____
____

Primary Care Physician ______________________________
Phone: ______________________________________

I. DRUGS AND MEDICATIONS:
List all medications you take, including dosage, including herbal supplements and vitamins ____
____
____
____
____

II. SURGERIES:
List all previous operations, year, and type of anesthesia.
(gen., local, spinal)
____
____
____
____
____

III. HAVE YOU HAD:	PLEASE	CIRCLE	(IF YES, PLEASE EXPLAIN)	Anesthesia Pre-Op For Anesthesiologist Use Only
1. High Blood Pressure	Yes	No		**PMH:**
2. Heart trouble or Heart Attack	Yes	No		
a. Chest pain or Angina	Yes	No		
b. Irregular Heart Beat	Yes	No		
c. Congestive Heart Failure	Yes	No		
d. Abnormal electrocardiogram	Yes	No		
3. Gastric Esophageal Reflux, Hiatal Hernia, Ulcers	Yes	No		
4. A recent cold, cough, or sore throat	Yes	No		
5. Asthma, Emphysema, bronchitis, or breathing problem	Yes	No		
6. Abnormal chest x-ray	Yes	No		**PSH:**
7. Diabetes	Yes	No		
8. Yellow jaundice/hepatitis/AIDS/HIV	Yes	No		
9. Kidney Disease or Thyroid Disease	Yes	No		
10. Abnormal bleeding problems	Yes	No		
11. Stroke, numbness, or weakness	Yes	No		
12. Epilepsy or convulsive seizures	Yes	No		
13. Broken bones, of back, neck, or face	Yes	No		**Physical Exam:**
14. Back trouble	Yes	No		
15. Unusual muscle problems or diseases	Yes	No		
16. Unexplained fevers or heatstrokes	Yes	No		
17. Bad reactions to anesthetics	Yes	No		
18. Any relative with bad reaction to anesthetics	Yes	No		
19. Psychological or emotional problems	Yes	No		
20. Any problems with motions sickness	Yes	No		
IV. DO YOU:				
21. Wear Dentures	Yes	No		
22. Have caps on teeth	Yes	No		**Plan:**
23. Drink alcohol (How much per day)	Yes	No		
24. Smoke (How much per day)	Yes	No		
25. Recreational Drug Use	Yes	No		
26. Exercise or have strenuous activity	Yes	No		
V. FEMALES: Last menstrual period	______ ______ ______			
VI. Are you aware there is a risk with EVERY Anesthetic given	Yes	No		

VII. Do you have questions or concerns you would like you discuss with your Anesthesiologist? ______________________________
____
____

Anesthesiologist: ______________________ **Date**: ____________ **Time**: ____________

Signed by Patient: ______________________ **Date**: ____________ **Time**: ____________

PATIENT LABEL HERE

LOS ALAMITOS
SURGERY CENTER

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article I: **Agreement to Arbitrate:** It is understood that any dispute as to medical practice, that as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim in the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdiction limit of the small claims court against the physician, and the physician' partners, associates, association, corporation, or partnership: and the employees, agents and estates of any of them, must be arbitrated including, without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper addition party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

____
Patient or Patient's Representatives Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

Continued on next page -

PHYSICIAN-PATIENT ARBITRATION AGREEMENT - Continued

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below. I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT.

By:	By:
Physician's or Duly Authorized Representative's Signature & DATE	Patient or Patient's Representative's Signature & DATE

Los Alamitos Surgery Center

Patient Sticker

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, ______________________________, understand that as part of my health care, Los Alamitos Surgery Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that **Los Alamitos Surgery Center** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Los Alamitos Surgery Center** reserves the right to change their notice and practices, even if prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **Los Alamitos Surgery Center** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient's Signature____ Date ____________________