

Greater New Orleans Surgery Center

ADDING NEW PROCEDURES TO THE APPROVED PROCEDURES LIST

Page 1 of 1

Reviewed: August 1, 2001
8/1/03, 6/24/08,
05/01/09
Implemented: August 1, 2001

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SUBJECT: Adding new procedures to the approved procedure list.

PURPOSE: To establish procedure guidelines for the Surgery Center.

SCOPE: Administrator, Medical Staff, and Medical Executive
Committee/Governing Body.

POLICY: Guidelines and plan will be used by all Medical Staff.

PROCEDURE:

Decisions as to the addition or deletion of procedures to the approved procedure list are based on criteria including by not limited to:

INITIAL

1. Medical history/physical condition of certain patient groups.
2. The standard of medical care in the individual community.
3. Consideration of the recovery period required for the procedure.
4. Procedures in which airway compromise is anticipated or expected.

TRAINING

1. The necessary training and competency required to perform the procedure.
2. The necessary training and competency required by the facility staff to care for the patient post-operatively.
3. Define criteria for the procedure for the physician competency.

COST

Review cost by looking at capital expense and reimbursement.

APPROVAL

A new procedure will not be performed until it is approved by the Medical Director, Medical Advisory Committee/Governing Body.

FOLLOWUP

1. Utilization review of 100% of first 10 cases will be performed and this will be reported to the Medical Advisory Committee/Governing Body.
2. Based on utilization findings the need for continued follow up will be determined.

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Greater New Orleans Surgery Center

AUTHORIZATION FOR DISCHARGE RELEASE

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Reviewed: August 1, 2001
8/1/03, 6/24/08,

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SUBJECT: Authorization for discharge release.

PURPOSE: To ensure patient safety from discharge to home after receiving anesthesia (excluding local anesthesia).

SCOPE: All patients discharged who refuse to stay until released by order of surgeon or anesthesiologist or all patients discharged via taxi without an escort.

POLICY: Patients cared for at the Surgery Center and having received anesthesia must be accompanied by a responsible adult who will stay with the patient upon discharge.

PROCEDURE:

- A. If the responsible person does not drive, they may accompany the patient in a taxi.
- B. Taxi - any patient wishing to leave the Surgery Center without an escort via taxi must sign an AMA (Against Medical Advise form).
- C. AMA (Against Medical Advise) - any patient wishing to leave Surgery Center before meeting discharge requirements of PACU or a specific order of surgeon or anesthesiologist must sign a discharge release AMA form. (See sample behind policy.)

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DAILY SURGERY SCHEDULE

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8/1/03, 6/24/08,
05/01/09
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SUBJECT: Daily surgery schedule.

PURPOSE: For communication of the scheduled cases and for preparedness of the staff for the necessary supplies and equipment needing for upcoming surgical procedures.

SCOPE: All personnel.

POLICY: The next days' schedule will be posted in the appropriate designated areas in adequate time to prepare for scheduled cases.

PROCEDURE:

The next day's schedule should be printed the day before by those in need. The schedule will be posted in the following designated areas:

A. O/R x 1.

The schedule should be faxed to Parish Anesthesia Associates and THEM Video on a weekly basis keeping a week ahead of schedule. Parish Anesthesia will contact scheduling daily to verify the next day's appointments. The schedule should also be sent to the transcription service, Accutran, via encrypted email.

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Any changes in the schedule after 1 p.m. for the next day will require notifying Anesthesia, PACU and OR staff, Them Video (if necessary) and any other contracted services when necessary.

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FACILITIES SCOPE OF PROCEDURES

Page 1 of 1

Reviewed: August 1, 2001,

~~01/01/02, 12/16/02~~

~~10/23/07, 6/24/08,~~

~~05/01/09~~

Implemented: August 1, 2001

~~10/23/07~~

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SUBJECT: Procedures the facility performs.

PURPOSE: To define the procedures that will be performed at the Greater New Orleans Surgery Center by specialty.

POLICY: Physicians will do procedures listed and/or approved by the Medical Advisory Board.

SCOPE: All physicians presented to and approved by the Medical Advisory Board/Governing Body.

PROCEDURE: Procedures that may be done at the Greater New Orleans Surgery Center, alphabetized by specialty, include, but are not limited to, the attached list.

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Greater New Orleans Surgery Center

HISTORY AND PHYSICAL EXAMINATIONS FOR PODIATRY AND DENTAL CASES

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03/03/09, 05/01/09,
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3/3/09

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SUBJECT: History and physical examinations.

PURPOSE: To provide optimum safety to the patient undergoing surgery.

SCOPE: All staff.

POLICY: It is the policy of the Surgery Center that patients of podiatrists and dentists are to have their history and physical exams done by the patients own physician.

PROCEDURE:

- A. Perioperative nurses working in preoperative area will verify a history and physical exam is present on patient's chart in advance of the procedure and completed by the patients own physician.

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Greater New Orleans Surgery Center

IDENTIFICATION BRACELETS

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SUBJECT: Identification bracelets.

SCOPE: All patients admitted to Surgery Center.

PURPOSE: The use of identification bracelets is a necessity for positive patient identification.

POLICY: Patients admitted to the Center must have an identification bracelet put on.

PROCEDURE:

- A. Patients must be identified by their bracelets before being taken into the operating room.
- B. These bracelets must remain on until discharge.
- C. If it is necessary to remove a bracelet due to the operation, obtain another bracelet and put it on the patient before removing the old one.

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Greater New Orleans Surgery Center

INFORMED CONSENT FOR HIV TESTING

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Reviewed: August 1, 2001
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Implemented: August 1, 2001

SUBJECT: Informed consent for HIV testing.

PURPOSE: To obtain information necessary for determination of medical treatment for the patient and the health care worker.

SCOPE: All patients and personnel.

POLICY: The Surgery Center will obtain a consent form from the patient prior to performing tests. Patient will be informed that testing is confidential. Infectious control policy will be followed as listed below:

PROCEDURE:

A. Patient consent form:

1. Obtain consent from patient. If consent is refused document refusal and do not order test.
2. If no blood specimen is available at lab and no prior consent has been obtained, HIV testing may not be done unless prior consent is obtained from patient.
3. There is no designated minimum number of hours postop before which a consent may be obtained. Ability to provide consent is dependent upon clinical assessment of each individual patient as well as the nature of the procedure and the medication given.

B. Personnel diagnosed with HIV:

1. Reasonable effort shall be made to permit facility personnel diagnosed as having the HIV infection to either continue to perform their assigned duties (unless unable to perform the essential functions of the position or the performance of those essential functions that would endanger the health and welfare or safety of themselves, facility patients or other employees), or offer them a position they are able to perform that would not pose a significant danger to health, welfare or safety of themselves or others.
2. To determine the danger posed, the facility shall consult public health authorities referencing appropriate guidelines concerning:
 - a. The nature of risk (how disease is transmitted).
 - b. Duration of risk (length of carrier infection).
 - c. The severity of risk based on consideration of the reasonable accommodations that can be provided to eliminate any substantial risk based on an individualized basis.

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3. Confirmed clinical cases of HIV in facility personnel are reported to Infection Control for immediate response to the health and educational needs of patients and employees. This information is confidential and disclosed only to persons having a need to know and only to protect the health, welfare and safety of patients and employees.
4. Employees believed exposed to body fluids of individuals with HIV shall immediately report to Clinical Manager so that they can evaluate the need for appropriate treatment.
5. Facility personnel who refuse to work with other facility personnel or patients, either suffering from or suspected to have HIV infection, should be referred to Clinical Manager. Infection Control Coordinator shall provide these individuals with the latest information concerning HIV infection, transmission and adequate safeguards against transmission. Facility personnel who have a reasonable basis for refusal (such as pregnancy or undergoing chemotherapy), may be offered a temporary transfer from immediate contact.
6. Personnel suffering from HIV shall be eligible for employee benefits (such as Workers Compensation disability) in the same manner as other employee entitlement.

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- C. The Surgery Center is committed to the provision of surgical, endoscopic and other like services to all patients who seek such services at our Surgery Center, including patients with AIDS (Acquired Immune Deficiency Syndrome) with the same dignity, compassion, competence and understanding.

In order to respect the dignity and rights of its patients, the staff and physicians of the Center have established and adopted the following policy guidelines:

1. PATIENTS:
 - a. The Surgery Center will maintain confidentiality (to include special handling of medical records, if appropriate) for all patients with AIDS, ARC or sero-positive results for the antibody to AIDS.
 - b. The Surgery Center will comply with all applicable federal, state and local laws and regulations as well as reporting requirements in the management for patients, employees or prospective employees with AIDS, ARC or HIV positive test results.
 - c. The patient's written informed consent will be obtained before AIDS and HIV virus screening tests are conducted.
 - d. AIDS or ARC and HIV sero-positive patients will have access to appropriate counseling and education from the attending physician or physician's designee to prevent spreading the HIV virus.
2. MEDICAL STAFF:
 - a. Medical staff members and staff affiliates who have confirmed positive blood tests for HIV virus are entitled to legal protection afforded to other handicapped individuals. Any medical staff member who is aware that they have clinical or laboratory evidence of AIDS must notify the Medical Director.

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- b. The Surgery Center recognizes that it will have to accommodate medical staff members and staff affiliates with this handicap.
- c. Medical staff members or staff affiliates who cannot perform the essential elements of their jobs without causing a present and substantial danger to the health and safety of themselves and others will have their medical staff privileges reviewed. The medical staff, through its usual committee structure, will provide direction or assistance in each individual case.
- d. Medical staff members will be expected to care for patients regardless of their disease or infectious condition in accordance with approved medical staff guidelines along with the medical and ethical guidelines promulgated by the American Medical Association or by their individual specialty society.
- e. Ongoing responsibility for the review and updating of the Surgery Center's AIDS policies and procedures will rest with the Medical Advisory Committee through its Infection Control function. The Medical Advisory Committee shall approve approval of all educational programs for employees and medical staff. The Surgery Center's Governing Body shall approve all actions and recommendations of the Medical Advisory Committee.

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HIV/HBV INFORMED CONSENT

This form, when signed, will indicate authorization and consent to obtaining blood from me for the purpose of conducting a HIV/HBV test.

In the event that blood or fluid exposure should occur, I understand that I will be notified.

I understand that the HIV test is not 100% reliable and may, in some cases, indicate that a person has antibodies to the virus when the person does not (false positive), or it may fail to detect that a person has antibodies (false negative). I have also been informed that a positive blood test result does not mean that I have AIDS, and that in order to diagnose AIDS, other means must be used in conjunction with the blood test. I understand that a second or confirmatory test may be necessary before any test results are released and that I will be provided with an opportunity for face-to-face counseling.

I understand that, if there is a positive test result, those health care practitioners who are directly responsible for my care and treatment will be informed of this result so that proper precautions may be observed.

I further understand that any information regarding my test results held by the health care facility, its employees or agents, any physician, laboratory or blood bank, any insurance company, health benefit plan, Medicare/Medicaid or other third party payor, the state or local Department of Health, or any other agency shall be strictly confidential and shall not be disclosed to any other agency or institution or made public except where my personal identifiers are removed from such information.

By my signature below, I acknowledge that I have read this consent form and understand the provisions for release of information set forth in this consent.

READ BEFORE SIGNING

DATE _____

PATIENT/EMPLOYEE

WITNESS

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Greater New Orleans Surgery Center

MEDICAL RECORDS

Page 1 of 4

Reviewed: August 1, 2001
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SUBJECT: Medical records.

PURPOSE:

- A. The primary purpose of the medical record is to document the course of the patient's illness and treatment during all periods of care. The record is important in medical practice. It serves as an instrument for communication among physicians and other professionals contributing to the patient's care and as a basis for planning and evaluating that care.
- B. The secondary purposes of the medical record are:
 1. To serve as a source for substantiation of the patient care services and treatment provided.
 2. To provide clinical data of interest to researchers and continuing education programs.
 3. To meet and support legal and quasi-legal obligations imposed on the Center and the physician.

SCOPE: All personnel.

POLICY: The medical record is the property of the Center and is maintained for the benefit of the patient, the physician and the Center.

PROCEDURE: Content and format:

- A. The medical record is used by practitioners in the management of patient care. Because of this use, the objectives of effective patient care should serve as the basis for determining content, methods of organizing clinical information, desired manner and style of recordings, adequacy and timeliness of entries and justification for exclusion or inclusion of information.
- B. Ownership:

Records of the Center, including medical records maintained for the benefit of the patient, the physician and the facility are regarded as the property of the Surgery Center. The medical information in the record remains privileged and may not be released without proper authorization.
- C. Security of records:
 1. Medical records may be removed from the facility jurisdiction and safekeeping only by court order, statute or subpoena.

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2. The Medical Records Department has established and implemented security measures that reasonably safeguard both the medical record and its information content against loss, defacement, tampering, unauthorized disclosure and use by all unauthorized persons.
3. The Director of the Medical Records Department is delegated the authority for safekeeping of all medical records, excluding x-ray films. Directors of other departments that maintain treatment records or files of medical information shall have on file with the Director of Medical Records a statement containing the following:
 - a. The physical characteristics of the file.
 - b. The security measures in place.
 - c. The sign-out system utilized if the records are circulated.
 - d. The destruction schedule for the records.
4. Responsibility for a disclosure of medical record information from these areas should be delegated to Center personnel who understand the confidentiality of the medical record and recognize the situations that require the advice of the Director of Medical Records.

D. Use of records for internal administrative purposes:

1. Medical Advisory Committee/Governing Body-Legal precedents recognize the right of access for the Medical Advisory Committee/Governing Body in order to ensure quality of patient care.
2. The managers of the facility have access to all records of patients whenever necessary to carry out their management responsibility. Except when laws or regulations dictate otherwise, the Administrator also has the responsibility for final decisions on what medical record disclosures may be made and the circumstances under which disclosures may be made.
3. The Risk Manager may review or obtain copies of the medical record without the authorization of the patient or guardian in connection with Risk Management duties and functions. All requests from attorneys, patients who request records for personal use or any unusual circumstances shall be referred to the Risk Manager before release. In the absence of the Risk Manager, the Clinical Manager will review the record.
4. Access to the medical record without patient authorization should be provided only on a need-to-know basis in the management of Center affairs, including that necessary for performing internal administrative tasks, conducting quality assurance programs, receiving legal counsel, planning health services, and surveying hospital-approved programs for accreditation compliance. Staff access to medical records shall be commensurate with the individual's responsibility and authority for conducting facility business.

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E. Other internal use:

1. In general, Center employees may not have access to any medical record of any patient. Employees have access to medical records in their true course of business. Confidentiality of medical information is maintained.
2. Because of its responsibility for determining whether the quality of care provided to all patients is consistent with standards as provided for in the medical staff bylaws and in the requisites for hospital accreditation, the Center can use the medical record information for quality evaluation without authorization of the individual patient to whom it pertains. However, all individual patient identification should be excluded from the routine report of such findings and recommendations. When circumstances dictate otherwise, a coded method of identification may be appropriate for internal use.

F. EXTERNAL AGENCIES

1. Contracts for outside services, such as microfilming, record copy services and data processing, should include a statement by that company assuming the responsibility for maintenance of confidentiality of all medical information processed by them.
2. Medical records will be made available for research to individuals who have obtained written approval for their project from the Administrator.
3. Release of information to attorneys will be done only if a properly executed authorization, court order or subpoena is presented. Patient records and HIV testing patient records may be released only with a detailed authorization or a court order.
4. Personnel who receive subpoenas for trial may review any treatment records to refresh their memory of the particular case. This review is to be done in the Risk Management Office. Copies of facility records should not be made nor taken to court by personnel other than Medical Records Department personnel.

In potential risk management cases, as a courtesy, the patient's attending physician should be notified whenever a record has been requested by attorneys representing the patient or another party or by courts of law by way of court order.

G. Release of information:

1. Information may be released verbally only to a physician or another facility where the patient is currently being treated. These verbal requests are handled on a "call back" basis to verify identity of the physician or hospital requesting information. Verbal information should be given

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only in an urgent or an emergency situation, and then a written authorization should be requested.

A report of information released should be filed in the record immediately stating the circumstances of the release and signed by the person making the release. (See Attachment) EXCEPTION: Verbal information will be given to hospital physicians or office staff when it pertains to patients treated by that physician or a member of that physician's group.

2. Any requests to dictate patient information over the telephone to any agency, even with a written authorization, will not be considered a valid request and will not be answered.

H. Authorization to release confidential information.

1. Information, which is considered to be privileged, may not be released to anyone without the written permission of the patient unless required by law. In general, requests for information are in writing. Verbal requests are discouraged and limited to emergency situations in which physicians or hospitals are requesting information. (See Verbal Requests for information.)

Non-privileged information is limited to the name of the patient and the admission and discharge dates of the patient.

NOTE: The blood type of a patient is considered confidential information.

2. A valid authorization to release medical information must according to HIPAA rules.
3. State law prohibits the release of information concerning HIV test results without the informed authorization of a patient or court order (a subpoena cannot be honored).
4. Release of records will be completed by Med South record management and not GNOSC staff.

I. Charges:

Charges will be made for copies of all medical records except for the patient's physician and other medical care facilities where the patient is being treated. The charge will be according to current state law.

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Deleted: a. Be in writing.¶
b. Be addressed to the facility.¶
c. Contain the name and address of the person or company to whom the information is to be given.¶
d. Be dated by the patient - less than 180 days prior to the current date.¶
e. Be signed by the patient with the following exceptions:¶
¶
1. If the patient is a minor (under 18 years of age), the authorization must be signed by a legal custody parent or legal guardian (must show proof of guardianship).¶
2. If the patient is incompetent, the authorization must be signed by the legal guardian (must show proof of guardianship).¶
3. If the patient is deceased, the authorization must be signed by the administrator or executor of the estate ¶
(must show proof of guardianship).¶
¶

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MEDICAL RECORDS¶

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Page 5 of 5¶
¶

Deleted: a. Medicare/Medicaid, Blue Cross/Blue Shield, Commercial Insurance Companies: Medical information can be released to these organizations if it is stated on the admission sheet that the patient is a beneficiary of the insurance plan requesting the information. Where it is not indicated that the patient is a beneficiary, no information shall be released until verification can be obtained or a valid authorization is received from the patient.¶
¶
b. Commercial Insurance: Insurance auditors wishing to personally review entire medical records for financial auditing purposes are to be referred to the Business Office Manager of the facility.¶
¶
c. Workers' Compensation Cases:¶
¶
1. Copies may be released to the employer or insurance carrier without patient authorization.¶
2. Copies must be released to patient's attorney at cost reproduction.¶

Deleted: If a patient requests information to take to his physician and there is insufficient time to mail the information, the patient will not be charged. By law, fee of \$1.00 per page for the first 25 pages and then .50 per page thereafter will be charged. ... [1]

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MEDICAL RECORDS - RULES & REGULATIONS OF THE MEDICAL STAFF

Page 1 of 2

Reviewed: August 1, 2001
8/1/03, 6/24/08, 05/01/09
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SUBJECT: Medical records rules and regulations of the medical staff.

PURPOSE: To outline regulations governing the responsibility of the medical staff for medical records as well as privileges afforded medical staff concerning same.

SCOPE: All medical staff.

POLICY: To adhere to local, state and federal regulations concerning the handling of medical records.

PROCEDURE:

- A. The attending physician, dentist or podiatrist shall be responsible for the preparation of a complete medical record for each patient.
- B. The patient's medical record must contain an operative report with a complete description of the operative procedure, any complications, prognosis, and the surgeon's signature.
- The surgeon shall see that the record is complete and signed.
- C. Orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a nurse and signed by the attending surgeon.
- D. Medical records remaining incomplete for one month following the patient's discharge will be considered delinquent.
- E. Surgical procedures performed shall be fully described by the operating surgeon.
- F. Tissue and foreign objects removed during the operative procedure shall be sent to pathology at the surgeon's request. The pathologist shall make such examination as may be considered necessary.
- G. Records shall remain the property of the Surgery Center and shall not be taken from the Center.
- In the case of re-admission of a patient, all previous records shall be made available for the use of the attending physician, dentist or podiatrist. This shall apply whether he be attended by the same doctor or another.
- H. Access to medical records of their patients shall be afforded to members of the medical staff.

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Deleted: Medical Record Checklist¶
¶
Left Side of chart (NONCLINICAL) (top to bottom) - first case on bottom/last case on top¶
These forms should always be in this order, nothing should be on top of these two documents¶
<#>Log for Accounting of Disclosures¶
<#>Acknowledgement of Receipt of Privacy Notice¶
These forms stay in this order for each visit (meaning you should have these forms in this exact order for every visit with the oldest visit on bottom and newest on top)¶
<#>Extra labels¶
<#>Patient Scheduling Sheet ¶
<#>Patient Information Sheet¶
<#>Copy of Drivers License or ID¶
<#>Copy of Insurance Card¶
<#>Patient/Benefit Verification Worksheet¶
<#>Print out from insurance company website or fax back¶
<#>Referral¶
<#>Patient Billing and Insurance information (received from the doctors office)¶
<#>Medicare Secondary Payor form¶
¶
Right Side of chart (CLINICAL) (top to bottom) - These forms should stay in this order for this order for each visit¶
<#>Post op phone call form &/or letter . ¶
<#>Completed or ¶
<#>3 attempts made and noted ¶
<#>Operative report ¶
<#>Completed¶
<#>Signed & dated within 30 days of surgery¶
<#>CC faxed to physician indicated and date faxed is noted¶
<#>Pathology report (if ordered)¶
<#>Discharge Instructions¶
<#>PACU record¶
<#>Signed and dated¶
<#>Post op orders ¶
<#>Physician signature¶
<#>Dated¶
<#>Nurse notation ¶
<#>Anesthesia record¶
<#>Anesthesiologist signature¶
<#>Patient Signature¶
<#>Perioperative record¶
<#>Signed and dated¶
<#>Patient Verification Form¶
<#>Anesthesia consent¶
<#>Anesthesiologist signature¶
<#>Patient signature¶
<#>Witness signature¶
<#>Dated¶
<#>Surgical consent¶
<#>Physician signature¶
<#>Patient signature¶
<#>Witness signature¶
<#>Dated¶
<#>Pre op nursing record (Procedure observation flow sheet for Pain Mgmt)¶
<#>Signed and dated ¶
<#>Physicians short stay record - H&P¶
<#>Completed, ¶ (... [2]

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Greater New Orleans Surgery Center

MEDICAL RECORDS - RULES & REGULATIONS OF THE MEDICAL STAFF

Page 2 of 2

Upon written permission of the Administrator these may be used for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients.

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· Upon written permission of the Administrator these may be used for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients.¶

- I. Subject to the discretion of the Administrator of the Surgery Center former members of the medical staff shall be permitted access to information from the medical records of their patients covering all procedures in which they attended such patient in the Center.

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Greater New Orleans Surgery Center

MEDICAL RECORDS CHART

Page 1 of 3

Reviewed: August 1, 2001
8/1/03, 6/24/08, [05/01/09](#)
Implemented: August 1, 2001

- SUBJECT:** The medical record chart.
- PURPOSE:** To assemble a complete medical record for each patient.
- SCOPE:** All personnel.
- POLICY:** The medical records chart reflects the entire course of the patient's care at Surgery Center and includes but is not limited to: preoperative testing, details of patient's stay at the Center, post procedure follow-up and financial records - any information concerning the patient which is available at the Center.

PROCEDURE:

- A. The medical records chart shall contain the following:
1. Face sheet
 2. History & physical
 3. Consent form
 4. Observation consent form ([if applicable](#))
 5. Patient preoperative anesthesia questionnaire
 6. Preop record
 7. Patient consent for anesthesia
 8. Orders
 - a. Preop Doctor's
 - b. Postop Doctor's
 - c. Anesthesiologist's
 9. Laboratory
 - a. EKG
 - b. X-rays
 - c. Urinalysis
 - d. Blood work
 - e. Pathology request
 - f. Pathology
 10. O/R record
 11. Intraoperative X-rays and pictures
 12. Dictated operative note
 13. Anesthesia record
 14. PACU record
 15. Written notes
 16. [Discharge summary](#)
 17. [Postoperative instructions](#)

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Greater New Orleans Surgery Center

THE MEDICAL RECORDS CHART

Page 2 of 3

B. Medical records comprising chart:

1. Face Sheet - Top sheet in chart which contains identifying information; i.e., name, date of birth, admitting surgeon and anesthesiologist. This sheet also lists the admitting and final diagnosis and code as well as the surgical procedure and code.
2. History and Physical - Each patient must have a history and physical before surgery. H&P should be done within 30 days of procedure and is current for 30 days after procedure. Updates are required to original H&P after 30 days if using for other procedures.
3. Consent Forms - Signed consent for surgical procedure.
4. Observation Consent - If used.
5. Physician's Orders and Progress Notes - Included are admission and discharge orders as well as any other orders necessary for good patient care.
6. Clinical Laboratory Reports - Results of lab work done.
7. EKG and Interpretation - If ordered.
8. Chest X-ray Report - If ordered.
9. Pathology Report - Reports for pathology on all tissue, etc. sent for examination.
10. O/R Record or GI Diagram Sheet or Laser Procedure Form - Completed and signed by circulating nurse.
11. Operative Report - Findings and procedures used by surgeon. Dictated and then transcribed by medical records. This report must be signed by the surgeon before the chart is considered complete.
12. Anesthesia Record or Nursing Graphics - Completed and signed by anesthesiologist or nurse.
13. PACU Record - Recovery record as well as anesthesiologist discharge summary.
14. Written Notes
15. Discharge Summary - Dictated or written by physician and signed.
16. Discharge Instructions - To be completed in duplicate by the PACU nurse according to the doctor's orders. The patient is given the original and the copy becomes a part of the permanent medical record.

C. Medical records chart flow procedure.

1. The front desk initiates the chart, which includes the forms to be completed during the course of the patient's stay:
2. The preop nurse, who admits patient, adds any documents that they have received which may include any lab, x-ray, ekg, preanesthesia record, medical clearance, etc.
3. Operating room nurse completes the Operating Room Record and adds data to the Charge Sheet or Preference Card. A copy of the pathology requisition is placed in the chart.

Deleted: Anesthesia record¶
17. . PACU record¶
¶

Deleted: ¶
18. . Written notes¶
19. . Discharge summary¶
20. . Postoperative instructions¶

Deleted: Observation Consent - If used.¶

Deleted: Consent Forms - Signed consent for surgical procedure.

Deleted: following

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a. Preop record¶
b. PACU record ¶
c. Consent forms¶
¶

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Greater New Orleans Surgery Center

THE MEDICAL RECORDS CHART

Page 3 of 3

4. Surgeon writes orders, post-op notes, discharge summary and signs chart in appropriate places.
5. For cases under anesthesia, the anesthesiologist completes the Anesthesia Record.
6. PACU nurse continues with the PACU Record. The nurse also completes the Discharge Instruction Sheet.
7. Medical Records personnel assemble and analyze chart, and file in Record Room.

NOTE: The medical records chart is to be maintained accessible through accurate indexing and filing on-site for a minimum of twelve (12) months, and then it is transferred to off-site storage. The record may be utilized:

- a. An "old" chart when patient is having surgery again;
- b. By attending physicians;
- c. By nursing staff for follow-up information or quality of care/audit activities;
- b. By Performance Improvement Committee for review/audit;
- c. By Medical Advisory Committee/Governing Body for review/audit.

The record must be returned intact to the Medical Records Department for filing.

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¶
Page 3 of 3¶

- ¶
- d. Anesthesia order sheet ¶
 - e. Operating room record form¶
 - f. Anesthesia record¶
 - g. Line item sheet¶
 - h. Doctor's order sheet¶
 - i. Progress note¶
 - j. Discharge instructions¶

¶
. Also included are:¶

- a. Lab, EKG and x-ray reports - when available.¶
 - b. Arm band.¶
- ¶
2. The holding area nurse, who admits patient, adds:¶
- ¶
- a. History & physical, when delivered by patient or surgeon.¶
 - b. Lab, EKG and x-ray reports received in holding area.¶

¶

3. Operating room nurse initiates and completes the Operating Room Record and adds data to the **Line Item Sheet**. A copy of the pathology requisition is placed in the chart.¶

¶

4. Surgeon writes orders, post-op notes, discharge summary and signs chart in appropriate places.¶

¶

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Greater New Orleans Surgery Center

MEDICAL RECORDS PROCEDURES

Page 1 of 2

Reviewed: August 1, 2001
8/1/03, 6/24/08, 05/01/09
Implemented: August 1, 2001

SUBJECT: Medical records procedures.

PURPOSE: To define processing and maintaining records maintained by the business office.

SCOPE: Business office personnel.

POLICY: The Surgery Center will have available records and information pertinent to the operation of the Center and necessary to procure reimbursement for services rendered by the Center.

PROCEDURE:

A. Records include but are not limited to:

1. An alphabetical list of personnel containing telephone numbers is kept in the PACU
2. Employee information, including employment application, references, etc., is retained in the Administrator's office. Employee files are maintained by the Administrator.
3. A day-to-day log of all procedures is kept in our financial management system.
4. The original record of each procedure is a part of the patient's chart and remains in Medical Records after discharge.
5. A record of specimens is included in the patient's chart.
6. Specimen and implant logs are to be kept for a minimum of three (3) years.
7. Policy & Procedure Manuals are to be kept in the Administrator's Office with a copy in the Clinical Managers office.
8. Licenses are located in the front office. Pharmacy and DEA licenses are posted in the Pharmacy. There is a "license" book kept in the Administrator's office.
9. Old policies and procedures are kept in a file and the new ones are placed in the Policy & Procedures Manual.

Deleted: Medical Record Checklist¶
¶
Left Side of chart (NONCLINICAL) (top to bottom) - first case on bottom/last case on top¶
These forms should always be in this order, nothing should be on top of these two documents¶
<#>Log for Accounting of Disclosures¶
<#>Acknowledgement of Receipt of Privacy Notice¶
These forms stay in this order for each visit (meaning you should have these forms in this exact order for every visit with the oldest visit on bottom and newest on top)¶
<#>Extra labels¶
<#>Patient Scheduling Sheet ¶
<#>Patient Information Sheet¶
<#>Copy of Drivers License or ID¶
<#>Copy of Insurance Card¶
<#>Patient/Benefit Verification Worksheet¶
<#>Print out from insurance company website or fax back¶
<#>Referral¶
<#>Patient Billing and Insurance information (received from the doctors office)¶
<#>Medicare Secondary Payor form¶
¶
Right Side of chart (CLINICAL) (top to bottom) - These forms should stay in this order for this order for each visit¶
<#>Post op phone call form &/or letter . ¶
<#>Completed or ¶
<#>3 attempts made and noted ¶
<#>Operative report ¶
<#>Completed¶
<#>Signed & dated within 30 days of surgery¶
<#>CC faxed to physician indicated and date faxed is noted¶
<#>Pathology report (if ordered)¶
<#>Discharge Instructions¶
<#>PACU record¶
<#>Signed and dated¶
<#>Post op orders ¶
<#>Physician signature¶
<#>Dated¶
<#>Nurse notation ¶
<#>Anesthesia record¶
<#>Anesthesiologist signature¶
<#>Patient Signature¶
<#>Perioperative record¶
<#>Signed and dated¶
<#>Patient Verification Form¶
<#>Anesthesia consent¶
<#>Anesthesiologist signature¶
<#>Patient signature¶
<#>Witness signature¶
<#>Dated¶
<#>Surgical consent¶
<#>Physician signature¶
<#>Patient signature¶
<#>Witness signature¶
<#>Dated¶
<#>Pre op nursing record (Procedure observation flow sheet for Pain Mgmt)¶
<#>Signed and dated ¶
<#>Physicians short stay record – H& ... [3]

Deleted: n "old" policies and procedures book

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Greater New Orleans Surgery Center

MEDICAL RECORDS PROCEDURES

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B. Coding medical records.

All medical records will be coded for diagnosis using ICD-9-CM coding and for procedures using CPT-4 coding.

C. Medical records retention.

1. Medical records will be kept on site for a minimum of 12 months. Medical records will be filed alphabetically. At the discretion of the business office the medical records may be filed off site.

2. Records will be kept ten (10) ~~years~~.

Deleted: years

Deleted: except those of minor patients

Deleted: Records of minor patients will be kept ten (10) years after the patient comes of legal age (18 years).

D. Storage of medical records.

1. Old records may be taken from the facility and stored at an offsite storage facility.

2. The offsite storage facility will file the charts in alphabetical order in a safe clean environment.

3. If a chart is needed for review, the storage facility will deliver the chart to the facility on a 24-hour notice.

4. If the chart is required on an emergency basis, the storage facility will be capable of retrieving the record within 1 hour or FAX the necessary documents to the facility.

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Greater New Orleans Surgery Center

PERIOPERATIVE NURSING CARE PLAN

Page 1 of 1

Reviewed: August 1, 2001
8/1/03, 6/24/08, 05/01/09
Implemented: August 1, 2001

SUBJECT: Perioperative nursing care plan.

PURPOSE: To provide high quality care and continuity to patients receiving care at the Surgery Center.

SCOPE: All nursing personnel.

POLICY: A care plan will be completed on patients entering the O/R suites.

PROCEDURE:

- A. Each nurse involved in the patient's care is responsible for completing his/her area.
- B. Once the goals are met and/or addressed in nurses' notes as to follow-up measures, the care plan will be complete.
- C. Each care plan will remain in the chart as part of the medical record.

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Greater New Orleans Surgery Center

PHYSICIANS' MEDICAL ORDERS

Page 1 of 1

Reviewed: August 1, 2001
8/1/03, 6/24/08, 05/01/09
Implemented: August 1, 2001

SUBJECT: Physicians' medical orders.

PURPOSE: To ensure the proper medical care for the patient.

SCOPE: All nursing personnel.

POLICY: All patients having a procedure at the Surgery Center will have medical orders written by the attending physician in order for the admitting nurse to proceed with the admission of the patient, or there will be standing orders specific to procedure and physician.

PROCEDURE:

- A. All patients will have medical orders written by the attending physician or specific standing orders.
- B. Each physician may provide standing orders for selected patients/procedures.
- C. Standing orders must be typewritten, specify the circumstances for which they are used and identify the physician.
- D. The preop nurse implementing the standing orders must verify physician and specific procedure and place the copy on the chart.
- E. Standing orders must be signed by the appropriate physician on arrival to the facility. Standing orders will be reviewed annually by the physician and signed off.
- F. Physician orders are signed by the nurse with name, status, date and time.

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Greater New Orleans Surgery Center

POLICY AND PROCEDURE MANUAL

Page 1 of 1

Reviewed: August 1, 2001
8/1/03, 6/24/08, 05/01/09
Implemented: August 1, 2001

SUBJECT: Policy and Procedure Manual.

PURPOSE: This manual is prepared for the personnel of the Surgery Greater New Orleans Surgery Center in an effort to provide them with information which will guide them in providing for the comfort, safety and welfare of the patients who come to the Center for care.

SCOPE: All personnel.

Deleted: perioperative nursing

POLICY: Outpatient surgical care is an inter-blending of highly technical skills, nursing judgment and humanitarianism directed toward assisting the surgeon and anesthesiologist in accomplishing a plan of care for the patient which will return him/her to the home environment in a period of time not necessitating an overnight stay away. This will be accomplished with the safety, dignity and individuality of the patient ever uppermost in our minds.

PROCEDURE:

- A. To provide the highest quality medical care in a safe, courteous, friendly caring atmosphere.
- B. To avoid separation of the patient from his/her family and familiar environment as much as possible.
- C. To provide and maintain suitable equipment and supplies necessary for performing surgery and caring for the patient postoperatively.
- D. To provide experienced, interested professional nurses to assist the surgeon with direct patient care.
- E. To promote cooperative planning and coordination of functions between the team members for the increased quality of patient care and job satisfaction.

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Greater New Orleans Surgery Center

RELEASE OF MEDICAL INFORMATION

Page 1 of 6

Reviewed: August 1, 2001
8/1/03, 6/24/08, 05/01/09
Implemented: August 1, 2001

SUBJECT: Release of medical information.

PURPOSE: Health-care facilities are obligated to safeguard all patient information since its ownership of the medical records is restricted by the rights of the patient.

SCOPE: All personnel.

POLICY: The Administrator has the primary responsibility for the release of patient information. The Administrator, in turn may delegate this responsibility to other staff members. It is the responsibility of all staff members to maintain absolute confidentiality. **Note: This policy will be overridden by the HIPAA policies**

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PROCEDURE:

A. GENERAL POLICY FOR RELEASE OF INFORMATION:

1. A Center employee must not reveal any medical information in possession of the Center as except as outlined below.
2. The Center will not voluntarily use the record to jeopardize any of the interests of the patient, with the exception that the Center itself will use the record, if necessary, to defend itself or its agents against accusations made by patients or others.
3. In case of readmission of a patient, previous records shall be available for the use of the attending physician. This shall apply whether the patient be free or pay and whether he be attended by the same physician or by another.
4. In legal use of the medical record, the record cannot be shown to any person without the authorization of the patient, except upon subpoena, court order or statues, in which case, the Center is under obligation to produce the record in Court.
5. Telephone requests by patients for information concerning their own records shall be referred to the Administrator.
6. Information on medical records requested by insurance companies shall be given out only on written authorization signed and dated by the patient (guardian, if a minor or if mentally incompetent, or nearest relative in case of death) unless this is an insurance plan that we are filing a claim to.

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Greater New Orleans Surgery Center

RELEASE OF MEDICAL INFORMATION

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7. Information on medical records may be turned over to the Center's legal representative to protect the interests of the Center in cases involving liability or compensation.
8. Information may be released to other Centers currently involved in the care of the patient without signed authorization by the patient but with the authorization of the attending physician.
9. Charges will be made for abstracts or summaries of all medical records except to the patient's physician, social service bureaus and attorneys representing the Center.
10. Medical records shall not be taken outside of the Center except upon receipt of a subpoena duces tecum, court order or statute, and they shall be taken only by the Director of Medical Records or her designee. If a medical record has been subpoenaed, it must not be left at the court without permission of the administrator. When the judge orders that a medical record be held, a receipt must be obtained from the court clerk and filed in the folder until the record is returned. A request should be made of the judge to have a photostatic copy of the medical record made and substituted for the original after admission of the record as evidence.
11. The patient may review his own records; however, in the best interest of the patient, it is the policy of this Center to encourage the approval and presence of the attending physician so that he may properly interpret the contents of the record (See Confidentiality Policy for more detailed procedure).
12. Medical Records will only be released by Med South Record Management with the exception as it relates to the claim. Deleted: MedSouth

B. RELEASE OF MEDICAL RECORDS:

1. Release of Information:
 - a. Non-confidential information is that which may be released without the express consent of the patient. This may include date of admission, date of discharge, name of attending physician, address on admission. Note: Consent for disclosure of client-identifying information is not required if proper consent has been obtained previously, if the duration of the consent has not expired, and if the specifications of the consent are the same. While it is permissible to give such information, always bear in mind the welfare and wishes of the patient and discretion in releasing the information.
 - b. Confidential information is any part of the patient's medical history, examination, test, treatment or progress report as recorded in the medical record. Information from medical records is released as follows:

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Greater New Orleans Surgery Center

RELEASE OF MEDICAL INFORMATION

Page 3 of 6

1. To patient's relatives - No information other than that classified as non-confidential is given to the patient's relatives. If patient requests his/her medical record or to receive information from the record, they must sign a release of medical information. Information can only be released upon patient's discharge.
2. To physicians - Information is given to any properly identified physician for his use in caring for the patient without the permission of the patient. In the case of an emergency, when a physician calls for information by phone, he is asked to identify himself and give the information desired. He is usually called back so that it is possible to verify the authenticity of the caller. In rare cases where a patient requests that no information be released, it is necessary to have the patient's written consent to give information to other hospitals or physicians.
3. To insurance companies - No information other than that classified as non-confidential is released to any insurance company without the written authorization of the patient except Blue Cross/Blue Shield (original policy includes authorization). With the written authorization from the patient, representatives from insurance companies are allowed to examine the records and may be furnished photostatic copy upon request. No information is given over the telephone.
4. To attorneys and other persons concerned with claims - No information other than that classified as non-confidential is released to any attorney or other person concerned with claims without written consent of the patient. This fact also applies to the physician's attorney and the patient's attorney. With a written consent from the patient, attorneys and other persons concerned with claims are allowed to examine the record and are supplied with photostatic copies, and charged for the copies.
5. To public health agencies - Public Health laws require that certain confidential information must be reported to the Public Health authorities. In these instances, no authorization is necessary. All other confidential information is released only upon presentation of written consent of the patient.
6. To public and voluntary welfare agencies - All reasonable assistance is given to the agencies but no confidential information is released without signed consent of the patient.
7. To Workmen's Compensation - The employer or the employer's insurer is supplied the portion of the employee's record which is requested without the written consent of the patient.

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Greater New Orleans Surgery Center

RELEASE OF MEDICAL INFORMATION

Page 4 of 6

8. Subpoenas - When the Center is served with a subpoena, usually the Director of Medical Records is the person who will go to court. If a subpoena duces tecum is served, then this will take the requested record to court with him/her.

2. Frequently Requested Information:

- a. Physician treating physician - no authorization necessary.
- b. Hospital treating patient - no authorization required.
- c. Insurance carrier – if related to payment – no authorization required.
- d. Lawyers either representing patient or opposition - authorization required.
- e. Veterans Administration - authorization required.
- f. Telephone requests - no information should be released.
- g. Legal authorities - authorization required for release of clinical information unless court order.
- h. Hospital personnel requesting to see their chart - refer to attending physician.

If in doubt about any information to be released, refer to the Administrator.

3. Content of Proper Authorization:

- a. Date: An authorization must be dated. If the authorization is not dated, the policy of the facility will determine whether or not it is accepted.
- b. Signature:
 1. A minor is under 18 years of age. An emancipated minor (one who is married) may sign his/her own authorization. A minor who is supporting himself/herself and not living at home is not EMANCIPATED.
 2. In the care of a minor child whose parents are divorced, the parent or person having legal custody of the child must sign the authorization.

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Greater New Orleans Surgery Center

RELEASE OF MEDICAL INFORMATION

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3. In case of a patient's death, the next of kin in order of priority or the court-appointed executor must sign the authorization. The order of priority is as follows:
 - a. In the case of a married deceased:
 - The surviving spouse
 - If no spouse survives:
 - An adult child of such marriage
 - In the event of a minor child of such marriage:
 - The guardian of such child, if there be one.
 - In the absence of such guardian:
 - The court having jurisdiction of the minor.
 - In the event neither spouse nor child survive:
 - Permission from a person who would be allowed to give permission as in the case of an unmarried deceased.
 - b. In the case of an unmarried deceased:
 - The father
 - The mother
 - The guardian
 - The next of kin.
 - c. In the absence of any of the foregoing, any person assuming custody of and responsibility of burial of the body. If two or more of the above-named persons assume custody, then consent of one is sufficient.
 - d. Name of the institution holding information/to make the disclosure.
 - e. Name of the party seeking information.
 - f. Full name of the patient.
 - g. Special information to be released, including dates.
 - h. Unemancipated minor requires signature of parent or legal guardian.
4. In the absence of a request for specific information, it is recommended that only the following be released:
 - a. Date of admission and discharge.
 - b. Final diagnosis.
 - c. Name and date of operation.
 - d. Name of attending physician and/or surgeon.

C. **RELEASE OF MEDICAL RECORDS:** (All Records Release should be processed by Med South Record Management)

Deleted: MedSouth

1. If a patient requests a copy of his/her medical records:
 - a. The request must be in writing.

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Greater New Orleans Surgery Center

RELEASE OF MEDICAL INFORMATION

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- b. Allow 15 days from the date of surgery for completion and processing of record before a copy is made. However, if record is complete prior to this time, the record copy can be released.
 - c. The patient may also pick up the copy in person. A release form is signed by the patient and witnessed.
 - d. Fees in accordance to state law will be applied
 2. If a doctor's office requests a copy of a medical record: (exception – surgeon performing case)
 - a. The request must be in writing.
 - d. A copy of the patient's signature authorizing release must accompany request.
 - e. Allow 15 days from the date of surgery for completion and processing of record before a copy is made. However, if record is complete prior to this time, the record copy can be released.
 3. If an insurance company or attorney's office requests a copy of a medical record:
 - a. The request must be in writing.
 - b. A copy of the patient's signature authorizing release must accompany request.
 - c. A payment in accordance to applicable state law
 - d. Allow 15 days from the date of surgery for completion and processing of record before a copy is made. However, if record is complete prior to this time, the record copy can be released.

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Greater New Orleans Surgery Center

SURGICAL SCHEDULING PROCEDURE

Page 1 of 2

Reviewed: August 1, 2001
8/1/03, 06/24/08, 05/01/09
Implemented: August 1, 2001

SUBJECT: Surgical scheduling procedure.

PURPOSE: Proper scheduling is necessary to communicate to all areas effectively providing quality of care.

SCOPE: Scheduling personnel.

POLICY: The person scheduling will follow proper procedure providing communication to all areas in the surgery center, leading to complete, thorough, quality patient care.

PROCEDURE:

A. Obtain from the doctor's office the day and time he/she prefers to perform the procedure and schedule the earliest opening in the appropriate room.

B. Obtain the following information and record on the scheduling sheet:

Deleted: (see attached)

1. Scheduled date and time.
2. Patient's name, age and sex.
3. Surgeon's name.
4. Operative procedure.
5. Diagnosis and diagnosis code.
6. Special equipment. Write on scheduling sheet in designated area.
7. Type of anesthesia.
8. Hours required (surgical time).
9. Patient's address.
10. Patient's home phone number and work number, if applicable.
11. Insurance information.
 - a. Name of company
 - b. Policy holder
 - c. Address for claim processing
 - d. Phone number for verification
12. Social Security number.
13. Some doctors only book patient by name and procedure and then FAX us the information later.

Deleted: (Copy of this sheet is given to the Materials Manager upon receipt from the front desk).¶

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Greater New Orleans Surgery Center

SURGICAL SCHEDULING PROCEDURE

Page 2 of 2

- C. It is essential that all information be complete, accurate and legible.
- D. Record patient, procedure, physician and anesthesia in scheduling book or computer. Put completed face sheet in designated file or chart (if a recurring patient) according to date of surgery.

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Greater New Orleans Surgery Center

TRANSLATING SERVICES FOR HEARING IMPAIRED & FOREIGN LANGUAGES

Page 1 of 1

Reviewed: August 1, 2001
8/1/03, 6/24/08, 05/01/9
Implemented: August 1, 2001

- SUBJECT:** Translating services for hearing impaired and foreign languages.
- PURPOSE:** To aid those patients who are hearing impaired or do not understand English.
- SCOPE:** All personnel.
- POLICY:** Patients who arrive at Surgery Center with a hearing impairment or inability to understand English without a translator will be provided with one.

PROCEDURE:

- A. In the event the services for hearing impaired patients are needed, personnel should contact the following agency: Associated Catholic Charities or any association that the patient regularly uses.
- B. In the event the services of a translator/interpreter would be needed for a patient speaking only a foreign language, personnel should contact the following agency: Any agency that the patient regularly uses.

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- a. Medicare/Medicaid, Blue Cross/Blue Shield, Commercial Insurance Companies: Medical information can be released to these organizations if it is stated on the admission sheet that the patient is a beneficiary of the insurance plan requesting the information. Where it is not indicated that the patient is a beneficiary, no information shall be released until verification can be obtained or a valid authorization is received from the patient.
- b. Commercial Insurance: Insurance auditors wishing to personally review entire medical records for financial auditing purposes are to be referred to the Business Office Manager of the facility.
- c. Workers' Compensation Cases:
 1. Copies may be released to the employer or insurance carrier without patient authorization.
 2. Copies must be released to patient's attorney at cost reproduction.
 3. Prior records or psychiatric records are not to be released.
- d. Outside Social Service Agencies: Social Service agencies must submit a written authorization from the patient prior to receiving confidential information.
- e. Specific agencies or persons: All listed below must have a valid authorization for the patient:
 1. Police
 2. FBI
 3. CIA
 4. Attorneys
 5. City Officials
 6. Spouse or relatives
 7. Home Health Agencies

Medical Record Checklist

Left Side of chart (NONCLINICAL) (top to bottom) - first case on bottom/last case on top

These forms should always be in this order, nothing should be on top of these two documents

Log for Accounting of Disclosures
 Acknowledgement of Receipt of Privacy Notice

These forms stay in this order for each visit (meaning you should have these forms in this exact order for every visit with the oldest visit on bottom and newest on top)

Extra labels
 Patient Scheduling Sheet
 Patient Information Sheet
 Copy of Drivers License or ID
 Copy of Insurance Card
 Patient/Benefit Verification Worksheet
 Print out from insurance company website or fax back
 Referral
 Patient Billing and Insurance information (received from the doctors office)
 Medicare Secondary Payor form

Right Side of chart (CLINICAL) (top to bottom) - These forms should stay in this order for this order for each visit

Post op phone call form &/or letter
 Completed or

3 attempts made and noted

Operative report

Completed

Signed & dated within 30 days of surgery

CC faxed to physician indicated and date faxed is noted

Pathology report (if ordered)

Discharge Instructions

PACU record

Signed and dated

Post op orders

Physician signature

Dated

Nurse notation

Anesthesia record

Anesthesiologist signature

Patient Signature

Perioperative record

Signed and dated

Patient Verification Form

Anesthesia consent

Anesthesiologist signature

Patient signature

Witness signature

Dated

Surgical consent

Physician signature

Patient signature

Witness signature

Dated

Pre op nursing record (Procedure observation flow sheet for Pain Mgmt)

Signed and dated

Physicians short stay record – H&P

Completed,

Signed and dated within 30 days of surgery

Ancillary results (Bloodwork, EKG, X-Rays, etc)

Pre op orders

Physician signature

Dated

Nurse notation

Section Break (Next Page)

Left Side of chart (NONCLINICAL) (top to bottom) - first case on bottom/last case on top

These forms should always be in this order, nothing should be on top of these two documents

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Extra labels
Patient Scheduling Sheet
Patient Information Sheet
Copy of Drivers License or ID
Copy of Insurance Card
Patient/Benefit Verification Worksheet
Print out from insurance company website or fax back
Referral
Patient Billing and Insurance information (received from the doctors office)
Medicare Secondary Payor form

Right Side of chart (CLINICAL) (top to bottom) - These forms should stay in this order for this order for each visit

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Physician signature

Dated

Nurse notation

Anesthesia record

Anesthesiologist signature

Patient Signature

Perioperative record

Signed and dated

Patient Verification Form

Anesthesia consent

Anesthesiologist signature

Patient signature

Witness signature

Dated

Surgical consent

Physician signature

Patient signature

Witness signature

Dated

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Physicians short stay record – H&P

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