Mt Sinai Downtown Perioperative Services Patient Registration Form for the PACC ASU and PST Units
(PLEASE PRINT CLEARLY AND COMPLETE ALL INFO REQUESTED BELOW)

1- Patient Info Only:

What is your gender identity (circle which applies): ____ Male, ____ Female, ____ Transgender

What is the name you wish to be addressed as? ______________________________

Patient name: ______________________ Date of birth: ____________

Address: ______________________________ apt #: ____________

City & State: ______________________ Zip code: ____________

Home phone number: ______________ Cell number: ______________

Work phone: ______________ Social Security #: ______________

Email: ______________________ Mother's first name only: ____________

2- Insurance type (Check all that apply) - Staff must copy the front & back copy of all insurance card/s):

Medicare _____ Healthfirst _____ United Healthcare _____ Oxford _____ Medicaid _____ HIP _____

BC/BS _____ GHI _____ No Fault _____ Workmen's Comp. _______

Other (identify which) ______________________________

Policy holder (check one): self _____ if other- give full name ______________________

Relationship to patient: ____________________

3- Employer of primary insurance policy holder:

Company name: ______________________________________

Company Address: ______________________________ suite/ floor: ____________

City/state/zip: ____________________ Work phone number: ____________________

4- Next of Kin or Emergency contact information:

Name: ____________________ date of birth: ____________ relationship: ____________

Address: ____________________ apt # _______ city/state/zip: ____________________

Home phone: ____________________ Cell phone: ____________________

Work phone: ____________________

5- Does Patient have a Health Care Proxy (check one only): no _____ yes _____ (if yes, patient must provide copy for chart)

Agent name: ______________________ relationship: ________________

Home address: ______________________ city/state/zip: ________________

Home phone: ________________ Cell phone: ________________

Mount Sinai Beth Israel

Mount Sinai Brooklyn

1222844

INFECTIOUS DISEASES SCREENING TOOL

PREGNANT PATIENTS:

Date: ____________

Did you travel outside the U.S. or to Puerto Rico during your pregnancy? ☐ Yes ☐ No
If yes, when and where ______________________

Did you travel to the Miami area *on or after* June 15, 2016? ☐ Yes ☐ No

Did your partner travel to the Miami area on or after June 15, 2016? ☐ Yes ☐ No

Did your partner travel outside the U.S. or to Puerto Rico in the past 6 months*? ☐ Yes ☐ No
If yes, when and where ______________________

PATIENTS TRYING TO BECOME PREGNANT:

Did you travel to the Miami area on or after June 15, 2016? ☐ Yes ☐ No

Did you travel outside the U.S. or to Puerto Rico in the past 2 months*? ☐ Yes ☐ No
If yes, when and where ______________________

Did your partner travel to the Miami area on or after June 15, 2016? ☐ Yes ☐ No

Did your partner travel outside the U.S. or to Puerto Rico in the past 6 months*? ☐ Yes ☐ No
If yes, when and where ______________________

ALL PATIENTS:

1. Have you traveled outside the U.S. in the past 3 weeks? ☐ Yes ☐ No
   If yes, where ______________________

   Has a close contact (household member) traveled outside the U.S. in the past 21 days (3 weeks)? ☐ Yes ☐ No
   If yes, where ______________________

2. Have you had close contact with a person with Middle Eastern Respiratory Virus (MERS), Measles, or any other known infectious disease? ☐ Yes ☐ No

3. Do you have a fever (Temp more than 100.4°F (38°C)) or feel hot? ☐ Yes ☐ No

4. Do you have a cough, shortness of breath, or a sore throat? ☐ Yes ☐ No

5. Are you vomiting or having diarrhea? ☐ Yes ☐ No

6. Do you have a rash? ☐ Yes ☐ No

PLEASE HAND THIS FORM TO YOUR PROVIDER

MRN:
V:

Sex: DOB:

Ambulatory Patient Notification Record

I acknowledge that I have been given the following Notices and forms, as required by State and Federal regulations where appropriate:

- New York State Patient's Bill of Rights
- New York State Parent's Bill of Rights
- Patient's Responsibilities
- Notice of Privacy Practices
- Health Information Exchange (HIE) and Healthix Consent Form
- An Important Message From Medicare About Your Rights
- New York State Health Care Proxy Form
- Summary of Policy on Advance Directives
- Patient Information on Pain Management
- Appendix & Glossary

By signing below, I acknowledge that I have been provided a copy of the aforementioned Notices and Appendixes, when applicable, and have therefore been advised about my rights and responsibilities as a patient, any options available to me regarding advance directives, of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

____
Print Name of Patient or Personal Representative

______________________________ ____________
Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the foregoing Notices upon registration because:

- o The patient refused to sign, despite good faith efforts;
- o The patient was unaccompanied and not alert or oriented;
- o The patient was unaccompanied and needed emergency care;
- o Other: ______________________________.

Employee signature: ____________________ Employee Title: ____________________

Print Name: ____________________ Date: ____________________

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MRN:
V: Sex: DOB:

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by **Mount Sinai Beth Israel and/or Mount Sinai Brooklyn** ("MSBI/MSB") with respect to such services and care unless the contracts between MSBI/MSB and my insurance company provides otherwise and/or unless otherwise provided by law. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to MSBI/MSB, to cover the cost of the care and treatment rendered to myself or my dependents in the hospital.

Upon receipt of an MSBI/MSB bill, I agree to immediately pay all amounts not covered by insurance unless otherwise provided by law. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by MSBI/MSB immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to MSBI/MSB for services rendered to me, I hereby give my consent to have an authorized representative of MSBI/MSB contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by MSBI/MSB which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize MSBI/MSB, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of MSBI/MSB charges and/or professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only Part A and Part B providers)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or MSBI/MSB Services to the physician (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that MSBI/MSB are participating providers in many health plan networks, and that a list of the plans that MSBI/MSB participates in can be found at http://www.mountsinaihealth.org/static_files/MSHL/Files/Feb16ContractedPayers%20MSB-MSBI.pdf

I understand that physicians and other providers who render services at MSBI/MSB may be employed by or contracted by MSBI/MSB, or may be independent practitioners who are **not** employed or contracted by MSBI/MSB. I further understand that physicians/providers who provide services at MSBI/MSB may not participate in the same health plans as MSBI/MSB, even if they are employed by or contracted by MSBI/MSB.

I understand that charges for physicians'/providers' "professional services" performed at MSBI/MSB are **not** included in MSBI/MSB's charges, and that physicians/providers may bill for their "professional services" separately from MSBI/MSB, even if they are employed by or contracted by MSBI/MSB.

I understand that I can check with the physician(s) arranging for my hospital services to determine: (1) the name, practice name, mailing address and telephone number of any other physician/practice whose services will be arranged by the physician; and (2) whether the services of physicians who are employed or contracted by MSBI/MSB to provide services (including anesthesiology, pathology and/or radiology) are reasonably anticipated to be provided to me.

I understand that I can determine the health plans participated in by physicians who are employed by MSBI/MSB by accessing the "find a doctor" toolbar at http://www.mountsinaihealth.org and navigating to physicians' profiles to view their insurance participation information.

I understand that I can obtain contact information for physician groups contracted by MSBI to provide hospital services at MSBI by visiting: http://www.mountsinaihealth.org/about-the-health-system/insurance-info/msbi.

I understand that I can obtain contact information for physician groups contracted by MSB to provide hospital services at MSB by visiting: http://www.mountsinaihealth.org/about-the-health-system/insurance-info/msb.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

Signature of Patient or Authorized Representative ______ Date ______ Time ______

Print Name of Patient/Authorized Representative ______ Relationship, if signed by person other than patient ______

Signature of Witness ______ Date ______ Time ______

Print Signature of Witness ______

61499 (03/16)

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NYS EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans. In the event an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

____

Signature of Patient **(Date)**

(Or the patient's representative who can consent to the release of the patient's medical records. If a parent signs for a minor child, indicate the age of the child. If a guardian or executor signs, include proof of the appointment.)

Print Name: ____

Patient's Health Plan ID#:____________________________________

MRN:
V: Sex: DOB:

EA 7/14

BETH ISRAEL MEDICAL CENTER

MRN:
V: Sex: DOB:

RELEASE FROM LIABILITY FOR PATIENT VALUABLES

Beth Israel Medical Center **CANNOT ACCEPT RESPONSIBILITY** for personal valuables maintained at your bedside. **ALL** valuables should be given to relatives or friends prior to admission. If no one accompanies you to the hospital, you should check **ALL** valuables with the cashier. Although your personal property is of importance to us, the primary concern of the **BETH ISRAEL MEDICAL CENTER STAFF** is for your health care needs and therefore the Medical Center

WILL NOT BE RESPONSIBLE FOR VALUABLES RETAINED BY PATIENTS AT THE BEDSIDE.

If you choose to retain your valuables at the bedside, you must sign the following disclaimer, releasing the hospital from any and all liability for the loss or damage to your personal property.

I, ______________________ understand that the Medical Center maintains a vault in the cashier's office for the safekeeping of all valuables, and that the hospital shall not be liable for loss or damage to personal property unless such property is deposited with the cashier for safekeeping.

I accept full responsibility for all personal property including valuables, monies, jewelry, or other belongings not deposited for safekeeping.

I HAVE READ THIS STATEMENT AND IT HAS BEEN FULLY EXPLAINED TO ME, I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

______________________ ______________________ ____________
Signature of Patient Signature of Witness Date

IF PATIENT IS UNDER 18 YEARS OF AGE, RELEASE MUST BE GIVEN BY PARENT OR LEGAL GUARDIAN. IF PATIENT IS PHYSICALLY OR MENTALLY UNABLE TO SIGN, RELEASE FROM LIABILITY MUST BE GIVEN BY NEXT OF KIN NOTED ON ADMISSION FACESHEET.

Patient is unable to sign because ______________________________

I am ______________________ of patient ______________________
(relationship of patient)

and hereby release Beth Israel from liability on behalf of the patient.

______________________ ______________________ ________ ________
Signature of consenting party Signature of Witness Date Time

3-145 (11/10)

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MRN:
V:
Sex: DOB:

HEALTH INFORMATION EXCHANGE (HIE) AND HEALTHIX CONSENT FORM

The Mount Sinai Health Information Exchange ("Mount Sinai HIE") and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

In this Consent Form, you can choose whether to allow the health care providers listed on the Mount Sinai HIE website www.mountsinaiconnect.org ("HIE Participants") to obtain access to your medical records through a computer network operated by the Mount Sinai HIE. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you. The list of HIE Participants is updated regularly.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of "The Mount Sinai Health System" (defined in MS HIE Fact Sheet) to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the State of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent gives your permission for any Mount Sinai program in which you are a patient to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE. PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. I can also change my decision at any time by completing a new form. You have the following choices below. Please check Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access ALL of** my electronic health information through the **Mount Sinai HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access** my electronic health information through the **Mount Sinai HIE** or and **I DENY CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ANY of** my electronic health information through **HEALTHIX** for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your medical records, including records that are available through the Mount Sinai HIE and Healthix. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by applicable law.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

PRINT NAME OF PATIENT | PATIENT DATE OF BIRTH

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE | DATE | TIME

PRINT NAME OF LEGAL REPRESENTATIVE (IF APPLICABLE) | RELATIONSHIP OF LEGAL REPRESENTATIVE TO PATIENT (IF APPLICABLE)

Mount Sinai Beth Israel   Mount Sinai Brooklyn

Mount Sinai HIE and Healthix Fact Sheet

Healthix

L..ails about patient information in the Mount Sinai HIE and Healthix and the consent process:

1. Definitions.

- "The Mount Sinai Health System" refers to Mount Sinai Doctors Faculty Practice, the Icahn School of Medicine at Mount Sinai, and the following 7 Member Hospitals:
  - Mount Sinai Beth Israel
  - Mount Sinai Beth Israel Brooklyn
  - The Mount Sinai Hospital
  - Mount Sinai Queens
  - Mount Sinai Roosevelt
  - Mount Sinai St. Luke's
  - New York Eye and Ear Infirmary of Mount Sinai

2. How Your Information Will be Used. Consistent with New York State and Federal law, your electronic health information may be used by the HIE and Healthix Participants to:

- Provide you with medical treatment and related services.
- Check whether you have health insurance and what it covers.
- Improve Payers and Insurers ability to meet quality and performance program requirements by having a more complete view of a patient's clinical information.
- Provide Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of healthcare services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
- Provide Quality Improvement Activities. These include evaluating and improving the quality of medical care (and related services) provided to you and all Mount Sinai patients and Healthix members and participating organizations.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

3. **What Types of Information About You Are Included**. If you give consent, the HIE Participants may access ALL of your electronic health information available through the Mount Sinai HIE and all employees, agents and members of the medical staff of Mount Sinai may access ALL of your electronic health information available through Healthix. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

• Alcohol or drug use problems	• Mental health conditions
• Birth control and abortion (family planning)	• HIV/AIDS
• Genetic (inherited) diseases or tests	• Sexually transmitted diseases

4. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current HIE Information Sources is available from Mount Sinai or your HIE Participant health care provider, as applicable. You can obtain an updated list of Information Sources at any time by checking the Mount Sinai HIE website http://www.mountsinaiconnect.org. You can also contact the Mount Sinai HIE Privacy Officer by writing to: HIPAA Compliance Office, The Mount Sinai Medical Center, 1 Gustave L . Levy Place, Box 1016, New York, NY 10029 or calling: 212-241-4669. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749.

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Return to Patient

5. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on the medical staff of an approved HIE or Healthix Participant and who are involved in your medical care; health care providers who are covering or on call for an approved HIE or Healthix Participant; designated staff involved in quality improvement or care management activities; and staff members of an approved HIE or Healthix Participant who carry out activities permitted by this Consent Form as described above in paragraph one.

6. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

7. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you are concerned that someone who should not have seen or gotten access to information about you has done so via the Mount Sinai HIE, call one of the HIE Participants you have approved to access your records, visit the Mount Sinai HIE website: http://www.mountsinaiconnect.org, contact the Mount Sinai HIE Privacy Officer at the address and number above, call the NYS Department of Health at 877-690-2211, or contact the Federal Office of Civil Rights at www.hhs.gov/ocr/hipaa.gov. If your concern relates to access to your information via Healthix, call The Mount Sinai Health System at 212-241-4669; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

8. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by an HIE or Healthix Participant to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. As stated in #2 above, if you give consent, ALL of your electronic health information, including sensitive health information will be available through the Mount Sinai HIE and Healthix. Some state and federal laws provide special protections for some kinds of sensitive health information, including related to: (i) your assessment, treatment or examination of a health condition by certain providers; (ii) HIV/AIDS; (iii) mental illness; (iv) mental retardation and developmental disabilities; (v) substance abuse; and (vi) genetic testing. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The Mount Sinai HIE, Healthix and persons, who access this information through these health information exchanges must comply with these requirements.

9. **Effective Period.** This Consent Form will remain in effect until the day you withdraw your consent or until such time the Mount Sinai HIE ceases operation, or, with respect to Healthix, until the day you change your consent choice or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

10. **Changing Your Consent Status.** You can change your Consent Status at any time by signing a new Consent Form and selecting the "I DENY CONSENT" on page 1 of the form. You can get this Consent Form from your provider or on the Mount Sinai HIE website on the "Protecting Patient Health Information" page, http://www.mountsinai.org/ms-connect/protecting-patient-health-information. Once completed, please give the form to your provider and he or she will update our records appropriately.

    Note: Organizations, including Providers, that access your health information through the Mount Sinai HIE and/or Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return the information or remove it from their records.

11. **Copy of Form.** You are entitled to get a copy of this Consent Form after you sign it if you so request.

BETH ISRAEL MEDICAL CENTER

MRN:
V: Sex: DOB:

PATIENT PRE-ANESTHESIA QUESTIONNAIRE

Name of Patient: ____________ Age: ______ Weight: ________ Height: ______

Date of Procedure: __________ Procedure: ____________ Surgeon: __________

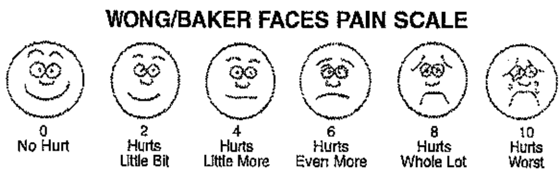
Person to drive you home: ____________ Telephone number: __________

Instructions: Please indicate if you have or have had any of the following. If you do not understand any question or are unsure of the answer, place a question mark next to the question.

1. Are you allergic to any medications? ☐ Yes ☐ No
   Please list: ____________
2. Do you or have you ever smoked? ☐ Yes ☐ No
   How much? ____________
3. Do you or have you used any recreational or "street drugs?" ☐ Yes ☐ No
   Describe: ____________
4. Do you drink alcohol? ☐ Yes ☐ No
   How much? ____________
5. Could you be pregnant? ☐ Yes ☐ No
6. Have you had a blood transfusion? ☐ Yes ☐ No
7. Are you willing to receive blood or blood products? ☐ Yes ☐ No
   If "NO", would you refuse blood/blood products under any circumstances including life threatening conditions? ☐ *Yes* ☐ *No*
   If "YES" please call the Bloodless Program Coordinator at 212-420-2430.
8. Asthma or wheezing? ☐ Yes ☐ No
9. Any other breathing or lung problems? ☐ Yes ☐ No
10. High blood pressure? ☐ Yes ☐ No
11. Is pain one of the reasons you are here today? ☐ Yes ☐ No
12. If yes, where is your pain? ____________
13. How long have you had your pain? ____________
14. Heart attack? ☐ Yes ☐ No
15. Angina or chest pain? ☐ Yes ☐ No
16. Irregular heart beat? ☐ Yes ☐ No
17. Any other heart problems? ☐ Yes ☐ No
18. Liver problems or hepatitis? ☐ Yes ☐ No
19. Kidney problems? ☐ Yes ☐ No
20. Diabetes or high blood sugar? ☐ Yes ☐ No
21. Epilepsy or seizures? ☐ Yes ☐ No
22. Stroke, paralysis, meningitis? ☐ Yes ☐ No
23. HIV or AIDS? ☐ Yes ☐ No
24. Blood disease or bleeding problems? ☐ Yes ☐ No
25. Sickle cell disease? ☐ Yes ☐ No
26. Have you or a blood relative ever had any problems with an anesthetic? ☐ Yes ☐ No
27. Can you climb a flight of stairs quickly or walk 4 miles in an hour? ☐ Yes ☐ No

Rate your pain by circling the face that best describes it:

WONG/BAKER FACES PAIN SCALE



From Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Reprinted by permission.

List any medicines, inhalers, pain medications, over the counter drugs, dietary supplements or herbal preparations you currently take or have taken in the last six months: ____________

List any operations you have had, along with the date of each: ____________

Additional comments or concerns not covered above: ____________

Signature of patient or person completing form ______ Date ______ Time ______

Reviewed by Anesthesiologist/P.A. ______ Date ______ Time ______

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ACKNOWLEDGEMENT OF NEED FOR ESCORT AT TIME OF DISCHARGE FROM AMBULATORY SURGERY UNIT

I, ______________________________, ACKNOWLEDGE THAT I HAVE BEEN INFORMED IN ADVANCE, OF MY APPOINTMENT FOR AMBULATORY SURGERY, THAT ANOTHER ADULT MUST ESCORT ME HOME AT THE TIME OF DISCHARGE. I UNDERSTAND THAT I WILL BE DISCHARGED ONCE I HAVE RECOVERED SUFFICIENTLY FROM ANESTHESIA AND SURGERY TO TRAVEL, BUT THAT I HAVE A RESPONSIBLE ADULT TO ESCORT ME HOME.

THIS PRECAUTION IS NECESSARY BECAUSE OCCASIONALLY PATIENTS EXPERIENCE PROBLEMS EVEN THOUGH THEY HAVE BEEN MEDICALLY STABLE PRIOR TO DISCHARGE. ACCORDINGLY, I HAVE MADE, OR WILL MAKE, ARRANGEMENTS FOR ANOTHER ADULT TO ESCORT ME WHEN I AM DISCHARGED FROM THE AMBULATORY SURGERY UNIT.

SIGNED: ______________________________ **(PATIENT)**

DATE: ______________________ **TIME:** ______________

SIGNED: ______________________________ **(WITNESS)**

DATE: ______________________ **TIME:** ______________

A Message to Our Patients

Hospitals are required to collect race and ethnicity information on all patients by the Department of Health (DOH). Racial and ethnic backgrounds may place people at different risks for certain diseases. By knowing more about your racial and ethnic background, we can better meet your health needs. Please review the selections on this card and select the ethnicity and race that best describes you.

RACE DESCRIPTION	
I	AMERICAN INDIAN OR ALASKA NATIVE
SEE BELOW	ASIAN
SEE BELOW	BLACK
SEE BELOW	NATIVE HAWAIIAN OR PACIFIC ISLANDER
W	WHITE
O	OTHER
U	UNKNOWN

ASIAN (Please Select One From the Options Below)	
AA	Asian Indian
AB	Bangladeshi
AC	Bhutanese
AD	Burmese
AE	Cambodian
AF	Chinese
AG	Filipino
AH	Hmong
AY	Indonesian
AJ	Iwo Jiman
AK	Japanese
AL	Korean
AM	Laotian
AO	Malaysian
AP	Maldivian
AQ	Nepalese
AR	Okinawan
AZ	Pakistani
AT	Singaporean
AU	Sri lankan
AV	Taiwanese
AW	Thai
AX	Vietnamese

BLACK (Please Select One From the Options Below)	
BA	African-American
BB	Barbadian
BC	Cape Verdian
BD	Congolese
BE	Dominica Islander
BF	Eritrean
BG	Ethiopian
BH	Gabonian
BJ	Ghanaian
BK	Grenadian
BM	Guinean
BN	Haitian
BO	Ivory Coastian
BP	Jamaican
BQ	Kenyan
BR	Liberian
AN	Madagascar
BS	Malian
BT	Nigerian
BU	Senegalese
BV	Sierra Leonean
BW	Somalian
BX	St Vincenian
BY	Sudanese
BZ	Tanzanian
B1	Togolese
B2	Trinidadian
B3	Ugandan
B4	West Indian
B5	Zimbabwean
B6	**Other:** East African
B7	**Other:** North African
B9	**Other:** West African
B8	**Other:** South African

NATIVE HAWAIIAN OR PACIFIC ISLANDER (Please Select One From the Options Below)	
PA	Carolinian
PB	Chamorro
PC	Chuukese
PD	Fijian
PE	Guamanian
PF	Guamanian or Chamorro
PG	Kiribati
PH	Kosraean
P1	Mariana Islander
PJ	Marshallese
PK	Melanesian
PL	Micronesian
PM	Native Hawaiian
PN	New Hebrides
PP	Palauan
PQ	Papua New Guinean
PR	Pohnpeian
PS	Polynesian
PT	Saipanese
PU	Samoan
PV	Solomon Islander
PW	Tahitian
PX	Tokelauan
PY	Tongan
PZ	Yapese
PO	**Other** Pacific Islander

ETHNICITY DESCRIPTION	
SEE BELOW	SPANISH/HISPANIC ORIGIN
N	NOT HISPANIC OR LATINO
U	UNKNOWN

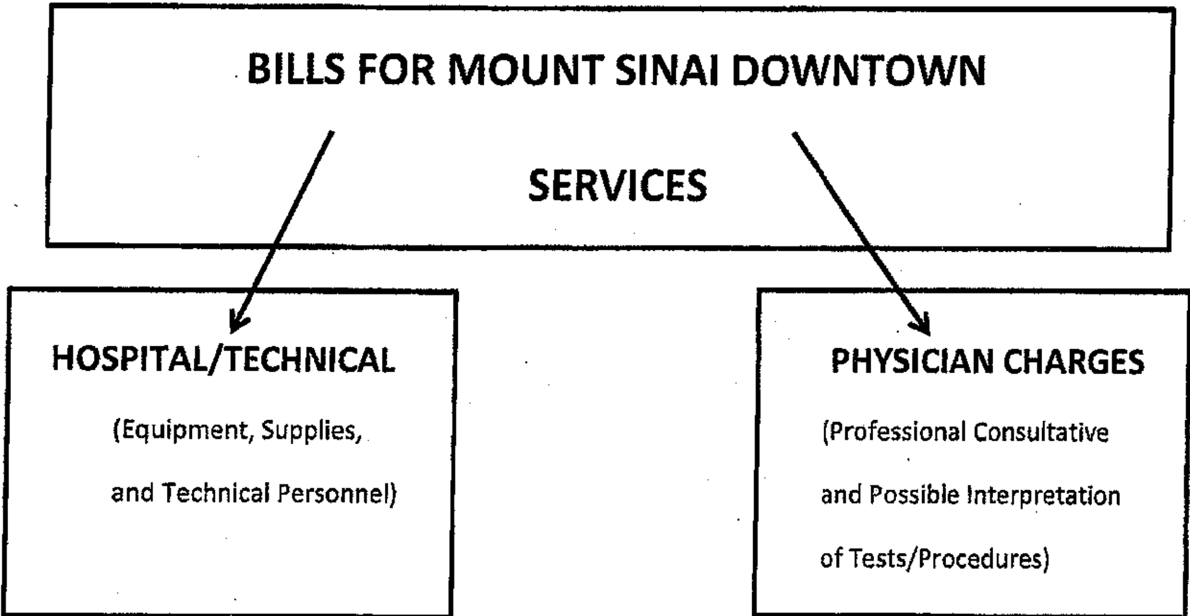
SPANISH/HISPANIC ORIGIN (Please Select One From the Options Below)	
1	Andalusian
2	Argentinean
3	Asturian
4	Belearic Islander
5	Bolivian
6	Canal Zone
7	Canarian
8	Castillian
9	Catalonian
10	Central American
11	Central American Indian
12	Chicano
13	Chilean
14	Colombian
15	Costa Rican
16	Criollo
17	Cuban
18	Dominican
19	Ecuadorian
20	Gallego
21	Guatemalan
22	Honduran
23	La Raza
24	Latin American
25	Mexican
26	Mexican American
27	Mexican American Indian
28	Mexicano
29	Nicaraguan
30	Panamanian
31	Paraguayan
32	Peruvian
33	Puerto Rican
34	Salvadoran
35	South American
36	South American Indian
37	Spaniard
38	Spanish Basque
39	Uruguayan
40	Valencian
41	Venezuelan

Mount
Sinai
Downtown

EXPLANATION OF CHARGES

You will receive **two types of bills** for services provided at the Mount Sinai Downtown.

1. You will receive a bill from the Mount Sinai Hospital which represents the fee for the technical/hospital portion of your visit.
2. You will receive a separate bill for each physician visit which represents the professional consultative service charge which may also include tests/procedure charges.



If you need further assistance or have any questions please feel free to contact our department financial counselors at: (212) 844-6610

For any Hospital Technical Fee Questions call: (888) 588-2506

For any Physician Charge Questions call: (212) 987-3100

Please sign below, acknowledging that you have been made aware of the above:

Patient Name Printed: ____________________

Signature: ____________________

Date: ____________________