You are scheduled to have your procedure at

1035 South Fair Oaks Avenue Suite 101 Pasadena, CA 91105 (626) 403-6488.

Please be aware, there is a $50 cancellation fee if the office is **NOT notified 24 hours** prior to your appointment.

Please arrive early as instructed prior to your appointment to complete all necessary paperwork.
Please bring your current picture ID and insurance card(s).
Your co-payment will be determined on the 1st of the month & due before services are rendered.
Should you have any questions regarding your copay, please contact your insurance provider.
Please make arrangements to have someone take you home.

******************************Remember********************************

No eating nor drinking 6 hours prior to your procedure unless instructed otherwise.
No alcohol 24 hours before your procedure.
STOP all blood thinning medications approximately 3-7 days depending on the medication (as instructed by you Physician) prior to your appointment.
Please view the following paperwork for a listing of the most common blood thinning medications.
Please take this time to complete the listing of all your medication and bring the paperwork with you to your appointment.
If this is your first visit, please bring a copy of your Advanced Directive, if you have one.

A nurse will call to remind you of your appointment prior to your scheduled appointment.
Should you have any questions, do not hesitate to contact us at
626-403-6488.

Thank you for your cooperation.

Pasadena Surgery Center
1035 S. Fair Oaks Avenue Suite #101
Pasadena, CA 91105
Tel: (626)403-6488 Fax(626)-403-6486
www.ThePasadenaSurgeryCenter.com

Servicing the Los Angeles, San Gabriel
San Fernando Valley & West Los Angeles
Communities

Pasadena Surgery Center

Address: 1035 S. Fair Oaks Ave #101, Pasadena, Ca, 91105

Phone: (626) 403 - 6488 • Fax: (626) 403 - 6486 • E-mail:

Notice of Language Assistance Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you.

ملحوظة: إذا كنت تتحدث اذكر اللغة التي تريد استخدامها إن وجدت، فإن خدمات المساعدة اللغوية المجانية متاحة لك.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

Discrimination is Against the Law

Pasadena Surgery Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Pasadena Surgery Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Pasadena Surgery Center:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as (i) qualified sign language interpreters; and (ii) written information in other formats (large print, audio, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as (i) qualified interpreters; and (ii) information written in other languages

If you need these services, call us at (626) 403 - 6488 or ask The Receptionist.

If you believe that Pasadena Surgery Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with The Director of Nursing. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, The Director of Nursing is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

PASADENA SURGERY CENTER
CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Patient Name: _____ ("Patient")

I understand that as part of Patient's healthcare, Pasadena Surgery Center ("Healthcare Provider") originates and maintains paper and/or electronic records describing Patient's health history, symptoms, examination and test results, diagnoses, treatment, any plan for future care or treatment, and other information relating to Patient's healthcare. I understand that this information serves the following purposes:

- A basis for planning Patient care and treatment;
- A means of communication among the health professionals contributing to Patient's care;
- A source of information for applying Patient's information to Patient's bill;
- A means by which a third-party payer can verify the services provided; and
- A tool for healthcare operations such as assessing quality and staff competence.

I understand that as part of Healthcare Provider's treatment, payment, and healthcare operations, it may be necessary to disclose Patient's health information to another person or entity.

I hereby consent to the foregoing uses and disclosures, including disclosures in electronic format.

I acknowledge receipt of Healthcare Provider's Notice of Privacy Practices (the "Notice") that provides a detailed description of the uses and disclosures of Patient's protected health information. I understand the rights and privileges described on the Notice.

I understand that Healthcare Provider reserves the right to change the content of the Notice and their privacy practices and to apply such changes to protected health information that was created or received prior to the issuance of a revised Notice, in accordance with Federal Regulations. Should Healthcare Provider make such changes, I understand that the revised Notice will be made available at Healthcare Provider's website at http://thepasadenasurgerycenter.com/, at their office, and to me – upon my request – by ☐ **mail** / ☐ **electronic transmission**.

I wish to have the following restrictions on the use and/or disclosure of Patient's information:

_____

I understand that Healthcare Provider is not required to agree to the requested restrictions, except as specified on the Notice. I understand that I may revoke this consent in writing, except to the extent that Healthcare Provider has already taken action in reliance thereon. I understand that by refusing to give consent or revoking this consent, Healthcare Provider may refuse to treat Patient as permitted by Federal Regulations.

I acknowledge receipt of the Notice, and I fully understand and ☐ **accept** / ☐ **decline** the terms of this consent.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

Representative's Signature: _____ Date: _____

Representative's Name: _____ Rel. to Pt. _____

NOTICE OF PRIVACY PRACTICES OF PASADENA SURGERY CENTER

1035 S. Fair Oaks Avenue Suite 101 Pasadena, CA 91105

HIPAA Privacy and Security Officer: (626)696-1413 • Medical Records: (909)493-3800

http://thepasadenasurgerycenter.com/

Effective Date: 10/17/2016

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**.

Our Responsibilities. Pasadena Surgery Center is required by the Health Insurance Portability and Accountability Act ("HIPAA") and other applicable laws to maintain the privacy and security of your Protected Health Information ("PHI"). We will promptly inform you if a breach occurs that may have compromised the privacy or security of your PHI. We must follow the duties and privacy practices described in, and give you a copy of, this notice. We will not use or disclose your information other than as described here unless you authorize us in writing. For more information, please visit www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Our Uses and Disclosures. We typically use or disclose your health information in the following ways:

1. Treatment. We may use and disclose your PHI for treatment purposes and share it with other healthcare providers who are treating you. For example, a specialist physician treating you for a specific condition may refer you to, and provide your PHI to, your primary care physician.
2. Payment. We may use and disclose your PHI to bill and get paid for our services. For example, we may give information about your treatment to your insurance to collect payment for the treatment.
3. Healthcare Operations. We may use and disclose PHI to operate our practice. For example, we may use your PHI to manage your care and improve the quality of our services. We may contact you to remind you of an appointment or to inform you of treatment alternatives or other benefits and services. PHI may be disclosed to business associates that provide services to us if the PHI is necessary for their services.

Other Uses and Disclosures. We are allowed—and may be required—to share your PHI in other ways. For more information, visit http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

1. Public Health and Safety. PHI may be shared as necessary to help prevent or reduce a serious threat to anyone's health or safety. PHI may be also shared to (i) prevent, and notify persons who may have been exposed to, disease; (ii) report vital events; (iii) report suspected abuse, neglect, or domestic violence (including child abuse/neglect); (v) report adverse reactions to medications; and (vi) help with product recalls.
2. Health Oversight Activities and Workers' Compensation. PHI may be disclosed to a health oversight agency as authorized by law. PHI may be disclosed for workers' compensation claims.
3. Law Enforcement. PHI may be disclosed to a law enforcement official or as required or permitted by law or in compliance with a court order or a grand jury subpoena. Such disclosures include (i) reporting a crime on our premises; (ii) helping identify or locate a suspect, fugitive, material witness, or missing person; (iii) reporting a death we suspect may be caused by a crime; and (iv) reporting the occurrence, location, and victim of a crime in case of an emergency.
4. Required by Law. PHI must be shared if required by federal or state law. The Department of Health and Human Services may require us to share your PHI to verify our compliance with federal privacy laws.
5. Legal Actions. If you are involved in a lawsuit, PHI may be disclosed in response to (i) a subpoena or other lawful process by someone involved in the lawsuit, but only if efforts have been made to inform you of the request or obtain an order protecting the PHI requested; or (ii) a court or administrative order.
6. Clinical Research Studies. Your PHI may be used and disclosed in the conduct of clinical research studies. Research studies must have gone through a special approval process to protect patient safety and confidentiality; however, prior to the approval process, researchers may be allowed to access limited data to identify patients who may be included in the study as long as they do not copy or remove any PHI. After receiving approval, researchers may contact you regarding your interest in participating in the study. You become part of the study only if you agree to join.
7. Coroners, Medical Examiners, and Funeral Directors. PHI may be disclosed to a coroner, medical examiner, or funeral director as necessary for their duties. HIPAA protects a decedent's PHI for fifty (50) years after the person's death.
8. Organ Donation. PHI of organ donors may be disclosed to organ procurement organizations.
9. Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement officer, your PHI may be disclosed to the institution or the officer as permitted or required by law.

10. Special Government Functions. PHI may be disclosed to federal officials for (i) national security activities; and (ii) the protection of the President or other heads of state. If you are/were a member of the armed forces, your PHI may be disclosed to military authorities as permitted or required by law.

Your Choices. Unless you object, (i) a family member, friend, or other person involved in your care or the payment for your care may receive PHI that relates to their involvement; and (ii) disaster relief organizations may receive PHI to coordinate your care or to notify your family and friends of your location or condition in case of a disaster. If you are unable to tell us your preference (ex. you are unconscious), we may share your PHI if we believe it is in your best interest. We may contact you for fundraising efforts, but you can tell us not to contact you again.

Uses and Disclosures that Require Written Authorization. The following uses and disclosures require your written authorization: (i) marketing; (iii) sale of your PHI; and (iii) most disclosures of psychotherapy notes. Furthermore, not every use or disclosure of your PHI is listed on this notice. Uses and disclosures of PHI not described above require your written authorization. You may revoke your authorization at any time by submitting a written revocation to us. A revocation will not affect prior uses and disclosures made in reliance on your authorization.

Your Rights.

1. Right to Inspect and Copy. You have the right to inspect and receive a paper or electronic copy of your PHI—other than psychotherapy notes. You may ask our Medical Records Department how to do this. A copy or summary of your PHI will be made available within thirty (30) days (or fewer as required by state law) of your written request. We may charge you a reasonable, cost-based fee. A fee will not be charged if the PHI is needed to claim Social Security benefits or other state or federal needs-based benefits. Requests may be denied in certain circumstances, but you may have the denial reviewed.
2. Right to Request an Amendment. To correct your PHI, you must send us a written request. Your request may be denied. You will be informed of the denial within sixty (60) days of your request.
3. Right to Accounting Disclosures. You have the right to request a list of times we disclosed your PHI except for treatment, payment, or operational disclosures and disclosures you authorized. The list can only go back six (6) years prior to the date of your request. To get such a list, you must send a written request to our Medical Records Department. We provide one (1) free accounting a year but charge a reasonable, cost-based fee for a list provided within twelve (12) months of a prior list.
4. Right to Request Confidential Communications. You may ask us to contact you in a specific way (ex. home or work phone) or to send mail to another address. We will accommodate all reasonable requests.
5. Right to Request Restrictions. You may ask us in writing to restrict the use or disclosure of your PHI for treatment, payment, or healthcare operations. We are not required to approve the request, and we may deny the request if it would affect your care. If you ask us to restrict the use and disclosure of your PHI to a health plan and such PHI pertains solely to a healthcare item or service for which you have paid out-of-pocket in full, we will comply with the restriction unless a law requires us to share the PHI.
6. Right to Representation. If you have a medical attorney-in-fact, legal guardian, or (if you are a minor) parent, such person can exercise your rights and make choices regarding your PHI. We verify any claim of authority to act on another's behalf.
7. Right to a Paper Copy of this Notice. You may ask for a paper copy of this notice at any time, even if you agreed to receive this notice electronically. We will promptly provide you with a paper copy.

Changes to this Notice. We can change the terms of this notice, and the changes will apply to all PHI we have about you. The new notice will be posted in our office and on our website: http://thepasadenasurgerycenter.com/.

For More Information or to Report a Problem. You may contact us for additional information. If you believe your right has been violated, you can file a complaint with either our HIPAA Privacy and Security Officer or the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you for filing a complaint.

HIPAA Privacy and Security Officer
Damian Dyer
224 N. Fair Oaks Avenue, Suite 300
Pasadena, CA 91103
Phone: (626)696-1413

Medical Records Department
10565 Civic Center Drive Suite 250
Rancho Cucamonga, CA 91730
Phone: (909)493-3800
Fax: (909)204-7867

Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: (877)696-6775
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Pasadena Surgery Center

Allergies: _____

List all of the medications you have taken at home in the last month. This includes those prescribed by a physician (**especially blood thinners and insulin**) **and** over- the-counter medications such as: Aspirin, Tylenol, vitamins, and herbs.

Medication	Dose (MG) (How much do you take?)	Route (by mouth, injection, patch)	Schedule (How often? When in the day?)	Last taken Y=yesterday T=today and time	Continue or start taking when patient gets home	
					YES	NO
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑

_____/_____

Admitting Nurse **Discharge Nurse**

You should take the medications checked YES by your physician. This list includes the new medication your doctor ordered for you today. If you have questions about any of the medication, please call the doctor who ordered it.

Physician: Please check YES for all medication (including over-the-counter) the patient should resume or begin taking today.

_____ _____ _____

Physician signature **Date** **Patient/Responsible person's signature**

Reconciliation Record	Patient ID

COUMADIN/WARFARIN PATIENTS ONLY

After consulting with your physician, please stop taking Coumadin/Warfarin

5 days before your procedure.

You must have LABS (INR / PT / PTT) completed within 24 HOURS of your procedure.

PLEASE HAVE YOUR LAB RESULTS FAXED TO (626)403-6486

IN ORDER TO HAVE YOUR PROCEDURE PERFORMED, YOUR INR MUST BE 1.2 OR LOWER

The following list contains SOME BLOOD THINNERS/ANTICOAGULANTS that need to be temporarily held for your procedure:

IF ONE OF THE FOLLOWING MEDICATIONS WAS STARTED AND IS MAINTAINED BY A PHYSICIAN, PLEASE CONTACT THE PHYSICIAN BEFORE STOPPING THAT MEDICATION.

WITH APPROVAL FROM YOUR PRESCRIBING PHYSICIAN, PLEASE STOP TAKING ALL ANTI-INFLAMMATORY, ASPIRIN CONTAINING, AND BLOOD THINNING MEDICATIONS ONE WEEK PRIOR TO YOUR PROCEDURE.

ADCIXIIMAB
ADVIL
AGGRENOX
AGGRASTAT
AKOLTOL TABLET
ALEVE
ALKA SELTZER
ANACIN
ANAPROX
ANAPROX DS
ANODYNO TABLETS
ANSAID
APIXABAN
ARGESTIC TABLETS
ARTHRALGEM TABLETS
ARTHRITIS PAIN FORMULA
ARTHRITIS STRENGTH BUFFERIN
ARTHROPAN LIQUID
ARTHROTEC
ASACOL
ASBERBUF TABLETS
ASCRIPTIN TABLETS
ASPERGUM
ASPIRIN

BAYER ASPIRIN TABLETS
BC TABLETS & POWDER
BRILINTA
BROMO-SELTZER
BUFF A COMPT
BUFFAPRIN
BUFFERIN W/ CODEINE #3
BUFFINOL TABLETS
BUTALBITAL/ASPIRIN/CAFFEINE
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE

CAMBIA
CATAFLAM
CARISOPRODOL/ASPIRIN
CELEBREX
CELECOXIB
CILOSTAZOL
CLINORIL TABLETS
CLOPIDOGIEL
CODEINE TABS W/ ASCRIPTIN
COUMADIN

DARVON WITH ASPIRIN
DAYPRO
DICLOFENAC POTASSIUM
DICLOFENAC SODIUM
DIFLUNISAL
DIPYRIDAMOLE
DISALCID TABLETS
DOAN PILLS
DOLOBID
DRISTAN
DUOPRIN
DURADYNE
EASPRIN
EC-NAPROSYN
ECOTRIN
EFFIENT
ELIQUIS
EMAGRIN TABLETS
EMLIRON
EMPIRIN TABLETS
EPTIFABATIDE (1 DAY)
EQAGESTIC TABLETS
ETODALAC
EXCEDRIN

FELDENE
FEVERFEW
FIORINAL
FIORINAL W/CODEINE
FISH OIL
FLECTOR PATCH
FLURBIPROFEN
FONDAPARINUX

GARLIC PILLS
GINKO BALOBA
GINSENG
GINGER PILLS
GLUCOSAMINE
GREEN TEA

HEPARIN (12 HRS)
HYDROXYUREA
HYDROCODONE/ IBUPROFEN

IBUPROFEN
INDOCIN
INDOCIN SR
INDOMETHACIN
INTEGRILIN

JANTOVEN

KETOPROFEN
KETOROLAC
KRILL OIL

LIMBREL
LODINE XL
LODINE TABLETS
LONOPRINOL TABLETS
LOVAZA
LOVENOX (12 HRS)

MAGAN TABLETS
MARNAL
MEASLRIN
MEFANAMIC ACID
MELOXICAM
MICRAININ TABLETS
MIDOL
MISOPROSTOL
MOBIC
MOBIDIN
MOBIGESIC
MOMENTUM
MOTRIN

NAPRELAN
NAPROXEN
NAPROXEN SODIUM
NAPROSYN
NABUMETONE
NEOCYLATE TABS
NORGESIC
NORGESIC FORTE
NOXAPARIN
NUPRIN

OMEGA FISH OIL
ORDUS TABLETS
ORPHENADRINE
ORVAIL CAPS
OXAPROZIN
OXYCODONE/ ASPIRIN

PABLATE SFF TABS
PEPTO-BISMOL
PERCODAN
PERCODAN-DEMI
PERSANTINE (2 DAYS)
PIROXICAM
PLAVIX
PLETAL
PONSETL
PRASUGREL
PRADAXA

RELAFEN
REPREXAIN
REOPROA

SALETO TABS
SALOCOL TABS
S-A-C TAB
SALSALATE
SK 65 CMPD CAPS
SOMA COMPOUND
SULINDAC
SUMATRIPTAN
STANDBACK POWDER
STREPTOKINASE
SYNALCOS CAPS

TALWIN CMPD CAPS
TICAGELOR
TICLID
TICLOPIDINE (10-14 DAYS)
TIROFITAN
TORADOL
TREXIMET

UROKONASE

VANQUISH
VERIN
VITAMIN E
VICOPROFEN
VOLTAREN
VOLTAREN XR

WARFARIN (5 DAYS)

XARELTO (3 DAYS)

ZIPSOR
ZOPRIN

Preparing For Your Procedure

Please talk to your physician about any daily medications you are currently taking, especially for heart, diabetes or blood pressure problems. Please inform the pre-op nurse of any medication you are taking. Be sure to mention any over-the-counter drugs such as Aspirin, Bufferin, Nuprin, Advil, Motrin, or Vitamin E.

When to notify your physician:

If for any reason you cannot keep your scheduled appointment, or you notice the following:

- You suspect that you are pregnant.

You experience any change in your health such as a cough, fever, cold, or are currently taking antibiotics.

Prior To Your Procedure

- For your safety, please do not eat or drink anything 6 hours (including no water) before your procedure, unless instructed by your physician. This includes hard candy, gum (unless ordered by your physician). Bathe or shower the night before and the morning of surgery to minimize the chance of infection.
- Teeth may be brushed but DO NOT swallow water. Refrain from smoking after midnight on the day before your procedure. Do not drink alcohol one day prior to procedure.
- Bring your insurance card and picture ID & any co-payments.
- You will be asked to sign consent forms for your procedure.
- Arrange for cash or a check to be held by friends or family waiting for you in case a prescription needs to be filled at a nearby pharmacy before you are discharged and/or for co-pay.
- Please leave children at home (If possible). Arrange care of your children for 24 hours following your procedure, as you could feel drowsy for that period of time.
- Leave your valuables, including your jewelry and watches at home.
- Dress in comfortable clothing & do not wear contacts lenses or make-up.
- Please bring your medication list form.

When to arrive at Pasadena Surgery Center:

Please plan to arrive promptly at the time given to you. After you have registered at the reception desk and completed all paperwork, you will be escorted to a private dressing area where you will be asked to put on a special gown, a cap and socks. Your clothing and other personal belongings will be stored in a locker during your stay. A nurse will spend time with you to answer any questions you might have while preparing / admitting you for your procedure.

After Your Procedure

What happens right after my procedure?

- While in the operating room, you will be transferred back to your bed and to your recovery area. You will be monitored for approximately 30 minutes. Some patients may feel slightly disoriented. You are encouraged to wake up, move your arms and legs and offered refreshments such as water or fruit juice.
- For your safety and well being, you must have a responsible adult drive you home after surgery, We cannot permit you to leave unescorted or in a taxi. Once you feel alert and comfortable, you will be asked to get dressed.
- Before being escorted to your car, we review your home-care instructions with you and give you a copy for easy reference.

Your Recovery at Home

What Should I do when I get home?

To hasten your recovery, we recommend that you rest comfortably when you get home. Patients typically feel sleepy most of the day. You may begin your regular diet and resume normal activities when you and your physician determine you are ready. A nurse will make a follow up call to find out how you are doing.

Dizziness and nausea are normal after receiving anesthetic; therefore, you should wait 24 hours after your procedure prior to:

- Driving or operating equipment
- Signing important papers or making significant decisions
- Drinking alcoholic beverages
- Taking any medication not prescribed or acknowledged by your surgeon.

ADVANCE HEALTH CARE DIRECTIVE FORM

CALIFORNIA PROBATE CODE SECTION 4700-4701

4700. The form provided in Section 4701 may, but need not, be used to create an advance health care directive. The other sections of this division govern the effect of the form or any other writing used to create an advance health care directive. An individual may complete or modify all or any part of the form in Section 4701.

4701. The statutory advance health care directive form is as follows: ADVANCE HEALTH CARE DIRECTIVE (California Probate Section 4701) Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to your or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures,and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care,including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent.Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive,as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care. After completing this form, sign and date the form at the end.The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have,to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

Part1
PART 1 POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____

(Name of individual you choose as agent)

_____ _____ _____ _____

(Address) (City) (State) (Zip)

_____ _____

(Home Phone) (Work Phone)

ADVANCE HEALTH CARE DIRECTIVE FORM

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____
(Name of individual you choose as first alternate agent)

_____ _____ _____ _____
(Address) (City) (State) (Zip)

_____ _____
(Home Phone) (Work Phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____
(Name of individual you choose as second alternate agent)

_____ _____ _____ _____
(Address) (City) (State) (Zip)

_____ _____
(Home Phone) (Work Phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____
(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

If I mark this box ( ), my agent's authority to make health care decisions for me takes effect immediately.

(1.4.) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____
(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ (a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

☐ (b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS AT DEATH (OPTIONAL)

(3.1) Upon my death (mark applicable box):

☐ (a) I give any needed organs, tissues, or parts, OR

☐ (b) I give the following organs, tissues, or parts only.

☐ (c) My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant
(2) Therapy
(3) Research
(4) Education

ADVANCE HEALTH CARE DIRECTIVE FORM

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____ _____ _____
(Address) (City) (State) (Zip)

_____
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____ _____ _____
(Address) (City) (State) (Zip Code)

_____
(phone)

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

_____
(Print your name)

_____
(sign your name) (date)

_____ _____ _____ _____
(Address) (City) (State) (Zip)

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness Second witness

_____ _____
(Print Name) (Print Name)

(Address)	(Address)
(City) (State)	(City) (State)
(signature of witness)	(signature of witness)

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

(signature of witness) (signature of witness)

PART 6
SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

(Print your name)

(sign your name) (date)

(Address) (City) (State) (Zip)