PETER A. MCINTYRE, D.D.S., P.C.

Consent for Outpatient Dental Care at St. Francis Medical Center Under General Anesthesia

Patient: _____ Date: _____

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY

The following must be fully completed, signed and returned to our office before an appointment can be set for hospitalization:

1. GUARDIAN INFORMATION (including guardianship documentation if applicable)
2. HOSPITAL CONSENT FOR MEDICAL TREATMENT (2 pgs.)
3. PATIENT BILL OF RIGHTS (2 pgs.)
4. INFORMED CONSENT SURGERY/PROCEDURE
5. INFORMED CONSENT FOR ANESTHESIA CARE

Please Note: Many pages in this packet require that the date and time of signature be included or they will NOT be accepted by the hospital.

When this packet has been completed and returned to our office, we will contact the appropriate party to schedule the above patient's hospital appointment. ***After*** this appointment has been scheduled, a full history and physical must be performed and signed by the patient's physician to be cleared for surgery. It is advisable to contact the primary care physician's office immediately after scheduling with our office to set up the physical appointment. Physicals must be completed ***no sooner than 30 days prior to admission***. The hospital will not accept physicals signed by nurse practitioners or physician's assistants; only MD or DO signatures will be accepted.

Please call Jennifer at (719) 475-2511 should you have any questions or concerns.

Thank you!

595 CHAPEL HILLS DR. STE. 105, COLORADO SPRINGS, CO 80920
PHONE: (719) 475-2511 · FAX: (719) 475-8425

PETER A. MCINTYRE, D.D.S., P.C.

GUARDIAN INFORMATION

PLEASE INCLUDE A COPY OF THE LEGAL DOCUMENT STATING GUARDIANSHIP OR POWER OF ATTORNEY WHEN APPLICABLE

Patient's Name: _____

Patient's Date of Birth: _____ SSN (**required**): _____

GUARDIANSHIP: You ***must*** provide a copy of the legal document stating guardianship of the individual if you are (1) his or her legal guardian, (2) his or her parent and the individual is over 18 years of age, or (3) his or her power of attorney.

Parent/Guardian/
Power of Attorney: _____

Relation to Pt: _____

_____
Address

_____
City, State, Zip

_____
Phone: (Home, Work, Cell and/or Fax)

_____
E-mail

By signing below, I verify that the above information is true and correct to the best of my knowledge.

_____ _____
Name Date

595 CHAPEL HILLS DR. STE. 105, COLORADO SPRINGS, CO 80920
PHONE: (719) 475-2511 · FAX: (719) 475-8425

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PATIENT BARCODE LABEL
MUST BE PLACED IN THIS SPACE

HOSPITAL CONSENT FOR MEDICAL TREATMENT

1. **CONSENT FOR HEALTH CARE SERVICES.** I voluntarily consent to and authorize the rendering of health care services, including routine hospital services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, including the use or potential use of restraint, which my attending physician or others holding clinical privileges consider necessary. I understand that health care services may be rendered by students, interns or residents under supervision. I further understand that the practice of medicine is not an exact science and I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in this health care facility. **I understand that my rights and responsibilities with regard to my care are described in more detail on the Patient Bill of Rights document.**

2. **INDEPENDENT PRACTITIONERS.** I understand that many of the professionals who provide care to me in the hospital are not employees or agents of the Hospital. These professionals may include my own physician, other physicians requested by my physician to participate in my care as well as emergency department physicians, radiologists, pathologists and anesthesiologists. As a result, I understand that these professionals will bill me for charges that are separate from those of the Hospital. **I understand that, in some cases, these professionals may not be participating providers under my insurance plan. The Hospital recognizes that this can be both frustrating and costly because I may be responsible for out of network costs or other costs because the professional does not have a contract with my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance.**

3. **MEDICARE and/or MEDICAID CERTIFICATION.** I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the Hospital on my behalf for the Hospital's and physicians' charges for which the Hospital is authorized to bill in connection with these health care services.

4. **RETENTION OF SPECIMENS.** I authorize the Hospital to take, retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience, all specimens, tissues, parts, or organs taken from my body during my hospitalization.

5. **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the Hospital and of physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service or following the medical screening exam. Any remaining charges are due and payable upon receipt of the bill. I understand the hospital may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the Hospital. **I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the Hospital or any entity to which the Hospital assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the Hospital or any entity to which the Hospital assigns my account, as well as to the use of technology including auto-dialing and or prerecorded messages in contacting me.**

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Hospital Consent for Medical Treatment
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6. **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to obtain all pre-authorizations and to comply with all requirements of any insurance or medical/hospital coverage plan upon which I am relying for coverage of the Hospital's and physicians' charges.

7. **ASSIGNMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to the Hospital and my physicians, to include any hospital-based radiologists, pathologists, anesthesiologists and emergency department physicians. I understand that I am financially responsible to the Hospital or my physicians for charges not covered or paid pursuant to this authorization.

8. **PERSONAL VALUABLES.** The Hospital maintains a safe for the safekeeping of any money or valuables. I understand that the Hospital does not assume responsibility for the loss, damage, or disposal of my personal property or money including jewelry, clothing, dentures, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item unless such money or property is deposited with the Hospital. I take full responsibility for any money or property retained in my possession/room or brought to me while I am a patient at the Hospital.

9. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Centura Health has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Centura Health's web-site. I understand this acknowledgement in no way affects the care I receive at the Hospital.

By checking one of the boxes below, I acknowledge:
☐ **I accepted a copy of the Notice of Privacy Practices**
☐ **I declined a copy of the Notice of Privacy Practices**

Facility Representative Comments: _____

10. **ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES.** I acknowledge that I understand that the Patient Bill of Rights document includes information on my rights and responsibilities as a patient, as well as information about how to bring concerns or grievances to the appropriate parties. I agree to accept the consequences if I disregard my rights and responsibilities.

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____ _____
SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON — NAME (PRINT)

_____ DATE _____ TIME _____
RELATIONSHIP/REASON WHY PATIENT IS UNABLE TO SIGN

ADDRESS OF PATIENT: _____

Centura Health

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Patient Bill of Rights

Patient Rights:

Centura Health Hospitals support the rights of all patients across the lifespan including geriatric, adult, adolescent, pediatric, infant and neonatal populations. These rights may be exercised through the patient individually or through their surrogate decision maker/legal representative.

You have the right to. . .

1. Be informed of your patient rights in advance of receiving or discontinuing care when possible.
2. Have impartial access to care and visitation. No one is denied access to treatment or visitation because of disability, national origin, culture, age, color, race, religion, gender identity, sexual orientation. No one is denied examination or treatment of an emergency medical condition because of their source of payment.
3. Give informed consent for all treatment and procedures with an explanation in layman terms of:
   - Recommended treatment or procedure.
   - Risks and benefits of the treatment or procedure.
   - Likelihood of success, serious side effects, and risks including death.
   - Alternatives and consequences if treatment is declined.
   - Explanation of the recovery period.
   - Whether physicians or qualified medical providers other than the operating physician will be performing important parts of the surgery or administer the anesthesia.
4. Participate in all areas of your care plan, treatment, care decisions, and discharge plan.
5. Have appropriate assessment and management of your pain.
6. Be informed of your health status/prognosis.
7. Be treated with respect and dignity.
8. Personal privacy, comfort and security to the extent possible during your stay.
9. Be free from restraints or seclusion imposed as a means of coercion, discipline, convenience or retaliation by staff.
10. Confidentiality of all communication and clinical records related to your care. Receive a copy of our Notice of Privacy Practices to inform you how your personal medical information can be used and disclosed and your rights related to your medical information.
11. Have access to telephone calls, mail, etc. Any restrictions to access will be discussed with you, and you will be involved in the decision when possible.
12. Have the right to choose a "visitor" who may visit you, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and your right to withdraw or deny such choice at any time. You also have the right to an identified "support person" who can make visitation decisions should you become incapacitated.
13. Have access to interpreter services at no cost to you or your companion when you do not speak or understand the language, as well as communication aides, at no cost, for the deaf, blind, speech impaired, etc., as appropriate.
14. Have access to pastoral/spiritual care.
15. Receive care in a safe setting.
16. Be free from all forms of abuse or harassment.
17. Have access to protective services (e.g., guardianship, advocacy services, and child/ adult protective services).
18. Request medically necessary and appropriate care and treatment.
19. Refuse any drug, test, procedure, or treatment and be informed of the medical consequences of such a decision.
20. Consent to or refuse to participate in teaching programs, research, experimental programs, and/or clinical trials.
21. Receive information about advance directives. Set up or provide Advance Directives and have them followed. Designate a surrogate decision-maker (legal representative) as permitted by law and as needed.
22. Participate in decision-making regarding ethical issues, personal values or beliefs.

Centura Health.

PATIENT BARCODE LABEL
MUST BE PLACED IN THIS SPACE

23. Have a family member or representative of your choice and your physician promptly notified of your admission to the hospital.
24. Know the names, professional status and experience of your caregivers.
25. Have access to your clinical records within a reasonable timeframe.
26. Be examined, treated, and if necessary, transferred to another facility if you have an emergency medical condition or are in labor, regardless of your ability to pay.
27. Request and receive, prior to the initiation of non-emergent care or treatment, the charges (or estimate of charges) for routine, usual, and customary services and any co-payment, deductible, or non-covered charges, as well as the facility's general billing procedures including receipt and explanation of an itemized bill. This right is honored regardless of the source(s) of payment.
28. Be informed of the hospital's complaint and grievance procedure and whom to contact to file a concern, complaint or grievance.

    Note: If you have financial issues or questions, please contact Centura Consumer Operations at (303) 715-7000. Toll free: 888-269-7001

    a. Our priority is for you to have an exceptional patient experience. If your concerns are not being resolved with your immediate care giver or the department manager, please call the patient representative; or the hospital operator by dialing "0" and asking for Patient Representative or RN Administrative Manager

    b. You may also contact The Health Facilities Division of the Colorado Department of Public Health and Environment and the Office of Civil Rights directly regardless of whether you first used the hospital's complaint and grievance process.

    The Colorado Department of
    Public Health and Environment
    4300 Cherry Creek Drive South
    Denver, CO 80222-1530
    Telephone: (303) 692-2827

    The Office for Civil Rights
    Department of Health and Human Services
    999 18th Street, South Terrace, Suite 417
    Denver, Colorado 80202
    Telephone: 303-844-2024
    TDD 303-844-3439
    Fax: 303-844-2025

    c. If after speaking with the hospital or system representative your complaint remains unresolved, you may contact The Joint Commission:

    The Joint Commission
    Division of Accreditation Operations,
    Office of Quality Monitoring
    One Renaissance Boulevard
    Oakbrook Terrace, IL 60181
    Telephone: 1-800-994-6610
    E-Mail: complaint@jcaho.org.
    Fax: Office of Quality Monitoring
    (630)792-5636.

    d. You also have the right to file a complaint with the Colorado Board of Medical Examiners, the State Board of Dental Examiners and the Colorado Podiatry Board if you have concerns with your physician, dental or podiatric patient care services, excluding fee disputes.

Patient Responsibilities:

You have the responsibility to . . .

1. Ask questions and promptly voice concerns.
2. Give full and accurate information as it relates to your health, including medication.
3. Report changes in your condition or symptoms, including pain, and request assistance of a member of the health care team.
4. Participate in the planning of your care, including discharge planning.
5. Follow your recommended treatment plan.
6. Be considerate of other patients and staff.
7. Secure your valuables.
8. Follow facility rules and regulations.
9. Respect property that belongs to the facility or others.
10. Understand and honor financial obligations related to your care, including understanding your own insurance coverage.

Signature: _____ Date: _____ Time: _____

Penrose-St. Francis Health Services
Centura Health

Patient Label

Informed Consent
Surgery / Procedure
ADM-120 (04/11) Page 1

1. **LOCATION OF PROCEDURE:** ☐ Penrose Hospital ☒ St. Francis Medical Center ☐ Other ____

2. OPERATION OR PROCEDURE: I _____ (patient or responsible party), authorize Peter A. McIntyre DDS (surgeon/proceduralist) and or any assistants to perform the following operation/procedure: _____

3. **I UNDERSTAND THE REASON FOR THE OPERATION/PROCEDURE IS** (Diagnosis/Condition): _____

4. **RISKS:** My surgeon/proceduralist has discussed with me the above operation/procedure, the anticipated benefits, likelihood of success, material risks and side effects. This authorization is given with the understanding that any treatment/procedure and recuperation involves some risks and hazards. The more common risks include infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, severe blood loss, blood transfusion, pneumonia and the following, if any. These risks can be serious and possibly fatal. _____

5. **ALTERNATIVES:** My surgeon/proceduralist has discussed the following alternatives and the risk, benefits and side effects as well as the results of the declining recommended or alternative therapies: N/A

6. **BLOOD TRANSFUSIONS: If a Transfusion is anticipated, complete Blood Consent ADM-109**

7. **ANESTHESIA:** For procedures performed without the presence of an Anesthesiologist I may receive medication given to reduce pain and/or anxiety during the procedure which would be administered by a qualified individual under direct supervision. These medications can carry risks, including but not limited to; death, allergic or other adverse reaction.

8. I understand that if a DO NOT RESUSCITATE order is in place prior to the procedure, it will be stopped for the duration of the procedure and recovery, unless otherwise indicated.

   EXCEPTION: I request that my DO NOT RESUSCITATE order remain in effect for the procedure. I have discussed this with my surgeon/proceduralist. _____Patient initials

9. **ADDITIONAL PROCEDURES:** If my physician discovers a different, unsuspected condition at the time of surgery, I authorize my surgeon/proceduralist to perform such treatment as deemed necessary.

10. **MEDICAL IMPLANTS/DEVICES IMPLANTED DURING OPERATION/PROCEDURE:** If required for my operation/ procedure, I authorize my surgeon/proceduralist to implant a prosthetic or artificial device and I understand the risks, possible side effects, and alternatives to the implant. In addition I understand that if applicable to my operation/procedure that my physician and/or medical facility will release my Protected Health Information to the appropriate device manufacturer(s) per State and/or Federal regulations.

11. **ASSISTANTS:** I understand that some aspects or important tasks of this operation/procedure may be performed by qualified healthcare providers (i.e. physician assistant, advanced practice nurse, resident) other than the primary surgeon, anesthesiologist or proceduralist. I understand that the care provided by these practitioners will be within the scope of their practice or privileges granted and will be performed in accordance with the state law and the hospital's policies. In the case of residents the care provided will be based on their skill set and under the supervision of their responsible practitioner.

12. **OBSERVERS/STUDENTS/VENDORS:** I authorize the presence of medical observers/students/vendors approved by my physician and the hospital during my procedure.
    ☐ I consent to observers/students/vendors being present as described to me.
    Name(s) if known: _____
    ☐ I DO NOT consent to observers/students/vendors being present.

13. **CONSENT DECLARATION:** I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel that the patient has been adequately informed and has consented.

_____ Signature of Surgeon/Proceduralist

_____ Date / Time

14. **PATIENT'S CONSENT:** I understand that no guarantees have been made to me regarding the results of this treatment/procedure and that it may or may not improve my condition. I have had sufficient opportunity to discuss my condition and treatment with my physicians and/or their associates, and all of my questions have been answered to my satisfaction. I believe that I have been given sufficient information and adequate knowledge upon which to make an informed decision about undergoing the proposed treatment/procedure. I have read and fully understand this form and I voluntarily authorize and consent to this treatment/procedure.

_____ Signature of Patient / Responsible Party

_____ Date / Time

_____ If phone consent-witness signature here

_____ Date / Time

Penrose-St. Francis
Health Services
Centura Health

CONSENTSGL

PATIENT LABEL

Informed Consent
for Anesthesia Care
POS-129 (8/10) 1 page

1. **LOCATION:** ☐ Penrose Hospital ☒ St. Francis Medical Center ☐ Other: _____

2. **DATE OF OPERATION/PROCEDURE:** _____ / _____ / _____

The type of anesthesia that you receive will depend upon the planned procedure, your physical condition, and your discussion with the physician. The anesthesia care may include monitoring only, local or topical anesthesia, intravenous sedation, peripheral nerve block, epidural or spinal anesthesia, general anesthesia, or a combination of techniques.

3. **TYPES OF ANESTHESIA TO BE USED:**

☐ **MONITORED CARE WITH OR WITHOUT SEDATION:** Includes the monitoring of at least blood pressure, oxygenation, pulse and mental state, giving relaxing medication or pain medication as needed. The level of consciousness may vary from wide awake to essentially unconscious depending on the needs of the case and wishes of the surgeon and patient.

☐ **REGIONAL**

- Epidural: A needle and/or small catheter is inserted into the epidural space (near the spinal nerves) so that anesthetizing agents may be given to provide anesthesia in the area of the procedure.
- Spinal: The anesthetic agent is injected into the spinal subarachnoid space to prevent sensation of pain.
- Nerve blocks: Local anesthetizing agents are injected into specific areas to inhibit nerve transmission.

☒ **GENERAL**

- Endotracheal: Anesthetic gases are passed through a tube placed in the trachea (windpipe) via the mouth or nose.
- Mask / laryngeal mask airway (LMA): Gases are delivered by a mask and/or tube that does not pass into the trachea (windpipe).

During your procedure conditions may change, thereby necessitating a change in the type of anesthesia or monitoring you are receiving. Any necessary changes would be made with your safety as the first concern.

Although safer today than ever before, the administration of anesthesia involves risks which may include but are not limited to: allergic or adverse reaction, aspiration of stomach contents or blood, backache, nerve/spinal damage, brain damage, dental injury, headache, inability to reverse the effects of anesthesia, bleeding, infection, localized swelling and/or redness, muscle aches, nausea, vomiting, sore throat, vocal cord damage, hoarseness, eye injury, vision loss/blindness, pain, paralysis, heart attack/cardiac arrest, pneumonia, respiratory distress, lung puncture, positional nerve injury, awareness during surgery, recall of sounds/speech, seizures, failure of local anesthetic to have intended effect, blood clots, other organ damage, serious disability, coma and death.

4. I understand that if a ***DO NOT RESUSCITATE*** order is in place prior to the procedure, it will be stopped for the duration of the procedure and recovery, unless otherwise indicated. This is because many drugs given and procedures performed during the course of routine anesthetic might be considered part of resuscitation under other circumstances.
EXCEPTION: I request that my ***DO NOT RESUSCITATE*** order remain in effect for the procedure. I have discussed this with my anesthesiologist. _____ *Patient Initials*

5. AIRWAY TRAINING: In order to promote quality medical care in the community, the anesthesia department participates in airway training and re-certification for students and experienced emergency medical technicians, paramedics and respiratory therapists. Specific procedures reviewed include mask ventilation and placement of airway devices. These procedures are always performed under the direct supervision of a staff anesthesiologist. Your consent for participation in this teaching service is optional.
I consent to participation in airway teaching as described above. _____*Patient initials*

CONSENT DECLARATION: I have explained the contents of this document including the alternative forms of anesthesia to the patient. I have answered all the patient's questions and, to the best of my knowledge, the patient has been adequately informed and has consented.

_____ _____
Anesthesiologist Print Last Name / Signature Date / Time

6. **PATIENT CONSENT:** I have informed my anesthesiologist of my known allergies and of all the medicines, remedies and drugs I am taking. I am aware and accept that no guarantees about the results of the procedure have been made.

I consent to the administration of anesthesia. I have been given the opportunity to ask questions and discuss the anesthetic plan. I understand that in addition to the anesthesiologist whose name appears on this document, other anesthesia providers may participate in my anesthetic care.

_____ _____ _____
Signature of Patient or Responsible Party Relationship (self, spouse, parent, etc) Date / Time

Original to Patient Record; Copy to Patient

Penrose-St.Francis Health Services
Centura Health.

Patient Label

Acknowledge Outpatient/Observation Services
#PEN-001 rev. 11/10

LETTERS

Acknowledge Outpatient/Observation Services

It is our goal to make your stay, regardless of duration, as pleasant as possible. Patient "status" may be confusing. You have been placed into an outpatient status for Observation or Extended Recovery. Within 24 hours, your physician should make a decision to either:

- Admit you for inpatient treatment, or
- Discharge you for continued outpatient follow-up care

Continuation of your outpatient care, evaluation and treatment is being provided in the privacy and comfort of a hospital room. Outpatient services such as these are billed differently than an Inpatient hospital stay, due to the differences in monitoring and documentation requirements. Your Medicare Handbook should describe your outpatient benefits.

Observation stays do not count toward the 3-day inpatient stay. Medicare requires for admission to a skilled care facility.

Medicare does not pay for your routine medications normally taken at home during this observation period. Only medication required for the purpose of your observation stay may be covered. You will be charged for routine home medications given from the hospitals stock. If you have any questions regarding medication coverage during Outpatient/Observation services, contact Medicare at 800-Medicare (1-800-633-4227).

Your nurse and doctor will frequently evaluate your symptoms/recovery in order to determine appropriate further testing, admission for continued care, transfer to another level of care or discharge to home. Discharge after a period of observation may be appropriate at any time, day or night. Please be sure you can make necessary arrangements for your transportation home.

We hope that this letter gives you answers to the questions you may have about your admission status. If you have any further question, please feel free to ask your nurse to contact the Nurse Case Manager on your unit.

Patient or representative: _____ _____
(signature) (date)

(Signature means RECEIPT of this letter of INFORMATION ONLY.)