Sweetwater Surgery Center, LLC
2761 Commercial Way • Rock Springs, Wyoming 82901
Phone: 307-382-6873 • Fax: 307-382-6869

Notice of Rights and Responsibilities-This Center has established a Patient's Bill of Rights and Responsibilities, which is provided verbally and in writing in a language and manner the patient, patient's representative or surrogate understands prior to their procedure. This Center expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the Center.

Advance Directive – Statement of Limitation: As a matter of conscience based on the minimal risk associated with the procedures performed at this Center, it is our policy regardless of the contents of any advance directive or instructions from a healthcare surrogate attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitating or other stabilizing measures and transfer you to an acute care hospital for further evaluation.

Please check the appropriate box.

☐ **Yes**, I have an advanced health care directive, living will and/or a power of attorney and understand the Statement of Limitations regarding this facility's policy.
☐ **I have** provided a copy of my advanced health care directive, living will and/or a power of attorney to the Center.
☐ **No,** I do not have an advance health care directive, living will and/or a power of attorney.
☐ **Yes,** I would like additional information on advanced health care directives including information on my states law regarding advanced health care directives.

Notice of Privacy Practices PHI and HIPPA- I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third – party payers.
- Conduct normal healthcare operations such as quality assessment and physician certification.

A complete copy of this Center's notice of privacy practice is posted in the Center. I have been informed by this Center of their written Notice of Privacy Practices containing a more complete description of the uses and disclosers of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy. I understand that I may request in writing that the Center restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that I may revise this consent in writing at any time, except to the extent that the Center has already acted relying on this consent.

I Give Permission for my protected health information (PHI) to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. ☐ **NO** ☐ **YES if yes, list below:**

Name: _____ **Name:** _____ **Date/Time:** _____

Ownership Disclosure -This Center is privately owned and has disclosed to the patient prior to the procedure the names of the owners of this facility. I have the right to choose this facility for my care.

Grievance Procedure -All alleged grievances will be fully documented, investigated and reported to the Administrator/Clinical Director of Sweetwater Surgery Center. Any substantiated allegation will be reported to the State of Wyoming and/ or local authority. The grievance documentation will be included in the process of how the grievance was addressed and the patient will be provided with written notice of the decision within thirty (30) days of receipt of the grievance.

By signing this document, I acknowledge that the above information was given to me prior to my procedure, and that I have read and understand the information. I agree to the policies of this Center. If I have indicated I would like additional information, I acknowledge receipt of that information.

_____

Patient Signature (If patient is unable to sign, please indicate relationship/ Witness Signature Date/Time

Revised 9/20/18.

Patient Demographic Information

Effective January 1st, 2025, The Centers for Medicare and Medicaid Services (CMS) require that all patients treated at ambulatory surgery centers are asked to provide demographic information as part of the registration process. This information will also help ensure that every one of every background gets the highest quality of care at our Center.

We'll keep this information confidential in your medical record. We appreciate your assistance in providing the following information.
You may choose more than one option.

☐ I decline to answer all questions

ETHNICITY

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

☐ Decline to Answer

RACE

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Some other race ☐ Unknown

☐ Decline to Answer

PRIMARY LANGUAGE

☐ English ☐ Spanish ☐ Chinese ☐ Tagalog ☐ Vietnamese ☐ Arabic

☐ Decline to Answer Other: _____

SWEETWATER SURGERY CENTER
ALLERGY AND MEDICATION RECONCILATION FORM

Patient: _____

This allergy and medication history is provided by: ☐ Patient ☐ Other: _____ Date: ____/____/____
(Name & Relationship)

ALLERGIES & REACTIONS (Circle all that you have had allergic reactions to and explain below)

☐ **Patient has No Know Allergies**

Allergen	Reaction

☐ See attached sheet for continuation of allergies & reactions.

CURRENT MEDICATIONS ☐ **Patient does not take any medication or anything listed below**

Including: Prescriptions, OTC Meds, Nutritional Supplements, Vitamins, Herbs, Birth Control Pills, Patches, etc...
(Do not use abbreviations)

Medication Name	Dose	Route	Frequency	For ASC Use Only Last Dose: Date	Time

☐ See attached sheet for continuation of current medications.

Allergies and Current Medications reviewed by:

PRE-OP RN: _____ Date: ____/____/____ Time: _____

DISCHARGE MEDICATION RECORD

☐ **Patient may resume all of the above listed medications as directed by his/her provider upon discharge.**

☐ **Patient should hold these medications** _____ **until** _____

New Discharge Medication	Dose	Route	Frequency	Reason for Taking	Notes/Instructions

☐ See discharge instructions for post-operative eye drop instructions

I have received and understand the instructions given me regarding the above discharge medications prescribed for me.

Patient / Caregiver Signature: _____

Instructions for the above discharge medications were given to patient / caregiver by:

PACU RN: _____ Date: ____/____/____ Time: _____

Original form remains with patient medical record / copy of form to patient/caregiver upon discharge