NORTHRIDGE MEDICAL CENTER

Northridge Outpatient Surgery Center
19871 Nordhoff St.
Northridge, CA 91324
Tel: (818) 359-8833 Fax: (877) 727.9225

Policy Regarding Health Care Directive

An advance care directive, also known as living will, are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity, and appoints a person to make such decisions on their behalf. A living will is one form of advance directive, leaving instructions for treatment. Another form authorizes a specific type of power of attorney or health care proxy, where someone is appointed by the individual to make decisions on their behalf when they are incapacitated. People may also have a combination of both.

I,______________________________________ do not have an advanced directive.
I,______________________________________ have an advance directive and will supply a copy.

I understand what an advanced directive is and acknowledge that Northridge Outpatient Surgery Center does not honor Advance Directives.

For more information about advance directives and how to obtain an advance directive, please visit the sites listed: www.partnershipforcaring.org; www.caringinfo.org/googlehealth; www.sos.ca.gov/ahcdr/forms.htm

Every effort will be made to treat the patient who exhibits cardiac arrest or any other life-threatening event. All staff members at the surgery center will be trained in CPR and/or ACLS and every effort will be made to revive the patient or attempt to save the patient's life.

______________________________________ ____________________
Patient Signature Date

______________________________________ ____________________
Witness Date

______________________________________ ____________________
Physician's Signature Date

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Patient Attestation of Receipt of Information

I have received information in a language I understand and have been given an opportunity to ask questions about:

- ✓ Advanced Directives
- ✓ Patient Notification (Grievance Process, Rights and Responsibilities, Ownership of Northridge Outpatient Surgery Center)
- ✓ I have read and understood the information on Advanced Directives
- ✓ I have received a copy of the Notice of Privacy Act

______________________________ ____________
Patient/Guardian/Representative Signature Date

Current Address:

____

Home Phone: ____________________

Cell Phone: ____________________

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MUTUAL ARBITRATION AGREEMENT

This Mutual Arbitration Agreement constitutes an integral part of a contract for medical services, represented by the Consent Form accompanied by this Mutual Arbitration Agreement (herein collectively defined as the "Contract"), by and between Northridge Outpatient Surgery Center ("NOSC") and physicians who have or may agree to be bound hereunder, and the Patient (NOSC, the physicians and the Patient are herein collectively to as the "Parties" or singularly as a "Party").

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical practice, that is as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this Contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the Parties that this agreement bind all Parties whose claims may arise out of or relate to treatment or services provided by the physician or NOSC, including any spouse or heirs of the Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim, I the case of any pregnant mother, the term "Patient" herein shall mean both the other and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against NOSC, the physicians, and their members, partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by NOSC or the physician to collect any fee from the Patient shall not waive the right to compel arbitration of any malpractice claim. However, following assertion of any claim against NOSC and/or the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all Parties. Each Party shall select an arbitrator (Party Arbitrator) within thirty days and a third arbitrator (Neutral Arbitrator) shall be selected by the arbitrators appointed by the Parties within thirty days of a demand for a Neutral Arbitrator by either Party. Each party to the arbitration shall pay such Party's pro rata share of the expenses and fees of the Neutral arbitrator, together with the other expenses of the arbitration incurred or approved by the Neutral Arbitrator, not including counsel fees or witness fees, or other expenses incurred by a Party for such Party's own benefit. The Parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Any Party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the Neutral Arbitrator.

The Parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be proper additional Party in a court action, and upon such intervention and joinder any existing court action against additional person or entity shall be stayed pending arbitration.

The Parties agree that provisions of California Law applicable to health care providers shall apply to the disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any Party may brig before the arbitration a motion of summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the Neutral Arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived forever barred if (1) on the date notice thereof is received the claim, id asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant falls to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to ant matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Enforceability:** If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Mutual Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOR RIGHT TO A JURY OR COURT TRIAL SEE ARTICLE 1 OF THIS CONTRACT.

______________________________ ______________________________ ____________________
PATIENT NAME PATIENT SIGNATURE DATE

______________________________ ______________________________
SIGNATURE OF DULY AUTHORIZED NOSC REPRESENTATIVE IF SIGNED BY OTHER THAN PATIENT, INDICATE RELATIONSHIP

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PATIENT ACCOMPANIMENT UPON DISCHARGE ADVISEMENT

For patient safety, you are hereby advised that is it the policy of Northridge Outpatient Surgery Center (NOSC) that all patients who receive medical services, requiring anesthesia, be discharged in the company of an adult friend or family member "responsible adult sponsor".

NOSC will make every attempt to accommodate your scheduling needs in order to ensure that you have a responsible adult sponsor to accompany you home following discharge.

Please be advised that if you arrive for your scheduled surgery and are not willing or able to provide the name and telephone number of a responsible adult sponsor to accompany you home following surgery, your surgery will be rescheduled to another date or your will not able to receive anesthesia and may elect to have the procedure done with local anesthetic only.

______________________________ ______________________________
RESPONSIBLE ADULT SPONSOR NAME CONTACT NUMBER(S) AND OR STATE "IN LOBBY"

I HAVE RECEIVED, READ AND UNDERSTAND THIS PATIENT ACCOMPANIMENT UPON DISCHARGE ADVISEMENT.

______________________________ ______________ ________
Patient Signature Date Time

____
If signed by other than patient please indicate relationship

PATIENT SELF ASSESSMENT

PLEASE FILL OUT THE INFORMATION ON THIS FORM WILL BE REVIEWED AND DISCUSSED WITH THE NURSE UPON ADMISSION

Do you have any ALLERGIES to Drugs/Medication (Circle one): NO / YES (list on line below) **ALLERGIC to Latex: NO / YES**

____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING ASPIRIN, NATURAL HERB SUPPLEMENTS, DIET PILLS):

____

____

LIST ALL PREVIOUS SURGERIES OR PROCEDURES (INCLUDING CHILDHOOD):

____

PAST OR PRESENT HEALTH HISTORY (CIRCLE YES OR NO)

HEIGHT: __________ WEIGHT: __________

HEALTH ISSUE		EXPLAIN	**HEALTH ISSUE**		EXPLAIN
HIGH BLOOD PRESSURE	YES NO		ARTHRTIS	YES NO	
STROKE	YES NO		HEADACHES	YES NO	
SMOKING	YES NO		THYROID DISORDER	YES NO	
LUNG DISEASE	YES NO		PAST ANESTHESIA PROBLEMS	YES NO	
DIABETES	YES NO		PROSTHESIS / IMPLANTS / PACEMAKERS	YES NO	
HEART DISEASE	YES NO		BLEEDING DISORDER	YES NO	
MITRAL VALVE PROLAPSE	YES NO		SEIZURE DISORDER	YES NO	
LIVER DISEASE	YES NO		GLAUCOMA	YES NO	
KIDNEY DISEASE	YES NO		RECENT COLD / FLU / INFECTION	YES NO	
CANCER	YES NO		PREGNANT YES NO N/A LMP:		

Patient Signature: ____________________ ____________________**Date:** ____________
If signed by other than patient, indicate relationship

DISCHARGE ADVISEMENT

The patient has the following items upon admission:

CLOTHING:

	ITEM:	GIVEN TO:
☐	BELT/SUSPENDERS	____________________
☐	BLOUSE/SHIRT	____________________
☐	BRA	____________________
☐	DRESS	____________________
☐	JACKET/COAT	____________________
☐	PANTS/SHORTS	____________________
☐	SLIP	____________________
☐	SHOES	____________________
☐	SOCKS	____________________
☐	SWEATER	____________________
☐	T SHIRT	____________________
☐	UNDERPANTS	____________________
☐	SKIRT	____________________
☐	OTHER	____________________
	DESCRIBE:	____________________

OTHER:

	ITEM:	GIVEN TO:
☐	DENTURES	____________________
☐	GLASSES	____________________
☐	CONTACTS	____________________
☐	HEARING AID	____________________
☐	PROSTHESIS	____________________
	DESCRIBE:	____________________
☐	CANE	____________________
☐	WALKER	____________________
☐	WHEELCHAIR	____________________
☐	CRUTCHERS	____________________
☐	OTHER	____________________

OTHER VALUABLES:

☐	WALLET/PURSE	____________________
☐	KEYS	____________________
☐	MONEY	____________________
	AMOUNT	____________________
☐	PAGER	____________________
☐	CELL PHONE	____________________
☐	MP3 PLAYER	____________________

JEWELRY:

☐	RING	____________________
	Describe:	____________________
☐	WATCH	____________________
☐	OTHER	____________________
☐	DEVICE	____________________
☐	NECKLACE	____________________
☐	EARRINGS	____________________

I understand that this facility cannot be responsible for money, jewelry, or other articles of unusual value. If I choose to keep my property with me, I acknowledge that the surgery center will not be responsible for them.

______________	________________	_________________
Patient Initials	RN/LVN Initials	Date

DISCHARGE:

The above marked articles have been returned to me at discharge.

______________	________________	_________________
Patient Initials	RN/LVN Initials	Date

PATIENT BELONGING CHECKLIST

PATIENT LABEL HERE