ENT & ALLERGY ASSOCIATES P.S.

Preoperative Information

Date of Surgery: _____

1. If your surgery is scheduled in the morning, you should have nothing to eat or drink after midnight the night before surgery.
2. When your child is in surgery, please do not leave the waiting area. He/she needs your presence and support, and you are expected to take him/her home shortly after surgery.
3. On the day of surgery, please limit the number of people accompanying the patient to two immediate family members. If possible, please do not bring young children with you. If you cannot find childcare, you will not be able to sit with the patient in the recovery room prior to discharge.
4. Please contact your insurance company prior to your surgery to make certain that your surgery is a covered benefit. Your policy is a contract between you and your insurance carrier. If you have any questions, please contact our office. The patient and/or guardian understands that they are ultimately responsible for payment if the insurance company denies payment for services.
5. Please be aware that medication refills (including pain medications) will be accomplished only during regular business hours (normally Monday to Thursday, 9 a.m. – 4 p.m.). Any request for medications outside of these hours (including weekends and holidays) will require a visit to the emergency room for evaluation by a physician.
6. If you cancel or reschedule your surgery date without a seven-day notice, it is our policy to charge a $500.00 fee.
7. Ownership: Hillside Medical Surgery Center is equally owned by Dr. Bennett and Dr. Edmond.
8. Patient Rights: A copy of Hillside Medical Surgery Center Patient Rights is included in your surgical packet.
9. Advanced Medical Directive: If you have an Advanced Medical Directive, you may provide the surgery center with a copy the day of your surgery. For your convenience, information about Advanced Medical Directives is in your surgical packet.
10. Ambulatory Surgical Facility Complaint Number: 1-800-633-6828

Patient name (print): _____

Signature of patient or parent/guardian: _____

Date: _____

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PROLIANCE SURGEONS®