Advanced Directives

Advance directives are legal documents that state a patient's preference in treatment and resuscitation - if the patient is unable to speak for himself or herself. There are two types of advance directives: People may also have a combination of both.

Living Will - This document states a patient's wishes in the withholding or withdrawing of life support, if the patient suffers from an incurable and terminal condition.

Durable Power of Attorney for Healthcare - This document designates another person to make healthcare decisions if the patient is no longer able to make them. This designated person also has the power to make the final decision about cessation of treatment.

Please choose one of the following that correspond to you:

I, _____ DO NOT have an advance directive.

I, _____have an advance directive **and will supply a copy**.

I understand what an advance directive is and acknowledge that this Surgery Center does honor Advance Directives.

If you are interested in acquiring an advanced directive, please ask our front desk for further assistance.
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 are 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**: _____ **Time**: _____

Witness Signature: _____Date: _____Time: _____

Physician Signature: _____**Date**: _____**Time**: _____

Soma Surgery Center*
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Somasurgerycenter.com

Anesthesia Consent Form

I understand that:

A. I will need anesthesia services for the surgical procedure(s) and that the type of anesthesia to be used will depend upon the procedure and my physical condition.

B. Anesthesia is a specialty medical service, which manages patients who, are rendered unconscious or with diminished response to pain and stress during the course of a medical, surgical, or obstetrical procedure.

C. During the course of the surgical procedure, conditions may require additional of different anesthetic monitoring or techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and well-being.

D. No guarantee has been made by anyone regarding the anesthesia services, which I am agreeing to have.

Types of Anesthesia

☐ *General Anesthesia*

1. Endotracheal Anesthesia Anesthetic and respiratory gases are passed through a tube placed in the trachea (windpipe) via the nose or the mouth.
2. Mask Anesthesia Gases are passed though a mask, which covers the nose and mouth.

☐ *Regional Anesthesia*

1. Epidural Anesthesia A small catheter is inserted into the spinal space so that anesthetic agents may be given to prolong the duration of anesthesia.
2. Spinal Anesthesia The anesthetic agent is injected into the spinal subarachnoid space to produce loss of sensation.
3. Nerve Block Local anesthetizing agent are injected into specific areas to inhibit nerve transmission.

☐ ***Monitored Anesthesia Care (MAC):*** include monitoring of blood pressure, oxygenation, pulse and mental state, supplementing sedation and malgesia as needed.

☐ *Local Anesthesia*

1. Local Anesthesia Anesthetizing agents are injected or infiltrated directly into a small area of the body, for example, the surgical site.
2. Topical Anesthesia Surface anesthesia is produced by direct application of anesthetizing agents on skin or mucous membrane.

Risk and Complications may include but are not limited to: allergic/adverse reaction, aspiration, backache, brain damage, coma, dental injury, headache, inability to reverse the affects of anesthesia, infection, localized swelling and or redness, muscle aches, nausea, ophthalmic (eye) injury, pain, paralysis, positional nerve injury, recall of sound/noise/speech by others, seizures, sore throat, wrong site for injection of anesthesia, and death.

I've been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent. I agree to the administration of the anesthesia prescribed for me. I recognize the alternative to acceptance of anesthesia for the procedure.

I hereby authorize and direct the anesthesiologist, (or anesthetist), to administer intravenous sedation, (MAC) or general anesthesia for the surgery I have consented to have performed. I understand the anesthesiologist (or anesthetist) will choose the type of anesthetic which he or she believes in their best professional judgment is the safest and most effective under the circumstances. I further understand that the type of anesthesia may be altered from that which was discussed by the anesthesiologist (or anesthetist) for the safety and wellbeing of the patient.

I understand that although favorable results can be expected, they cannot be and are not guaranteed. There is no guarantee against poor results or complications, either expressed or implied.

It is my understanding as the patient, or that of my legal representative, that the anesthesiologist (or anesthetist) will have complete charge of the administration and maintenance of the anesthesia during the planned procedure. I acknowledge that anesthesia is an independent function apart from the surgery. Due to this fact an adverse result from a surgical procedure may not relate to the results from the anesthesia administered.

I also agree to pay all anesthesia fees for those services and understand those fees will be separate from the surgery fees.

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

Anesthesiologist Signature: _____ Date: _____ Time: _____

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Consent for Treatment

I, _____Hereby authorize and request Dr. _____to perform the following procedures _____

_____

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given.

I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they may be deemed necessary or appropriate.

The risks and benefits of the procedure have been explained to me. I recognize that, though good results are expected, No guarantee or assurance of results can be made. Complications can occur with every surgical operation and every type of treatment- no matter how simple. The only warranty is that your surgeon will do his best to give you the best possible results.

I understand that there are certain medical and surgical alternatives to this procedure and I have been given information regarding other medically and surgically feasible forms of care. I hereby agree to fully cooperate with the doctor and to follow all instructions given to me with respect to my after surgical care.

I permit Dr._____ to take photographs and/or videotapes of me for educational and teaching purposes during the course of my hospital, outpatient or research treatment. The photographs and information relating to my case may be published or used for any other professional purpose. My personal information including my identity will not be revealed in these images.

I authorize the review of my medical records by a non-staff physician (peer reviewer) in the interest of improving patient care. I also authorize all surgery center personnel do honor any Advance Directives.

All my questions have been addressed and answered and I voluntarily give my signed authorization for this procedure.

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

Physician Signature:_____ _____ Date: _____ Time: _____

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Corona Virus Risks & Complications

Patient name: _____

The novel coronavirus, COVID-19, has caused a global pandemic. Its clinical presentation varies from asymptomatic or mildly symptomatic, to life-threatening complications and death. Unfortunately, there is no effective treatment and a vaccine has not been developed yet. If your COVID-19 status is unknown, we cannot specifically comment on potential complications that may occur. To reduce the risks associated with the COVID-19 infection, we are implementing safety precautions and following protocols consistent with the CDC and state recommendations. All patients and staff will be checked for fever or signs of illness upon entry to the facility. All staff will wear personal protection equipment to reduce any chances of transmitting any disease through oronasal airways. The risks, benefits, alternatives and decision to proceed with the procedure will be made in conjunction with you, the patient. However, we cannot guarantee that you will not become infected during your treatment at our practice. By signing this written consent, you acknowledge that you have been informed about the potential risks to your health related to COVID-19 while undergoing treatments for your pain during this pandemic.

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

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Financial Consent

Agreement to Pay Facility Fee, and Assignment of Insurance Benefits

Thank you for choosing Soma Surgery Center, Inc. ("Soma Surgery Center"). This is an agreement between you and Soma Surgery Center regarding payment for: (a) the use of Soma Surgery Center's facilities; and (b) any services that may be provided by Soma Surgery Center.

Facility Fee

Soma Surgery Center charges a facility fee. That facility fee includes charges for the operating room, the recovery room, equipment, maintenance, supplies, and for certain nonphysician staff, such as nurses. Soma Surgery Center's facility fee does not include the professional fees of your surgeon, anesthesiologist, or pathologist, each of whom are independent professionals, and none of whom are employed by Soma Surgery Center.

Agreement to Pay Facility Fee

The undersigned agrees, whether he or she signs as the patient, or as the patient's authorized representative, that, in consideration of the facilities to be provided by Soma Surgery Center, and in consideration of any services to be rendered, to the patient, by Soma Surgery Center, that he or she will pay a facility fee, to Soma Surgery Center, in accordance with Soma Surgery Center's regular rates.

Assignment of Insurance Benefits

Insurance is a contract between you and your insurance company. Soma Surgery Center is not a party to that contract. But, as a courtesy to you, Soma Surgery Center will bill your insurance company for the facility fee. And, to assist Soma Surgery Center in billing your insurance company, the undersigned, whether he or she signs as the patient, or as the patient's authorized representative, authorizes both the patient's physician, and Soma Surgery Center, to release any medical information and records, or other personal information, reasonably necessary to obtain payment from the insurance company.

The undersigned, whether he or she signs as the patient, or as the patient's authorized representative, hereby authorizes direct payment, to Soma Surgery Center, of any insurance benefits otherwise payable to, or on behalf of, the patient or the undersigned, for Soma Surgery Center's facility fee. But the undersigned, whether he or she signs as the patient, or as the patient's authorized representative, understands and agrees that he or she is financially responsible for any portion of Soma Surgery Center's facility fee that is not paid by insurance.

Responsibility for Costs of Collecting Payment

If the patient's account with Soma Surgery Center becomes past due, Soma Surgery Center will seek to collect the debt owed to it. And if Soma Surgery Center refers the patient's account to a collection agency, the undersigned, whether he or she signs as the patient, or as the patient's authorized representative, agrees to pay all of the collection costs that are incurred. Similarly, if Soma Surgery Center employs an attorney to collect the debt owed to it, the undersigned, whether he or she signs as the patient, or as the patient's authorized representative, agrees to pay all reasonable attorney's fees, and all court costs, incurred in collecting the debt. In the case of any lawsuit arising out of this agreement, the undersigned, whether he or she signs as the patient, or as the patient's authorized representative, agrees that the venue for that lawsuit will be the County of Los Angeles, State of California.

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Possible Waiver of Confidentiality

The undersigned, whether he or she signs as the patient, or as the patient's authorized representative, acknowledges and understands that, if the patient's account is referred to a collection agency, or to an attorney, for collection, or if the past due status of the account is reported to a credit reporting agency, then the fact that the patient underwent a procedure at, or received treatment at, Soma Surgery Center may become a matter of public record.

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____Date: _____Time: _____

Physician Signature: _____Date: _____Time: _____

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Hand washing to Prevent Infection

Germs and infection

The purpose of SOMA Surgery Center's Infection Control Program is to prevent the spread of germs. Germs and infections can travel from patient to patient, from patient to staff and visitors or from staff to patients and visitors. This information sheet tells you about guidelines to reduce your risk of infections.

Clean your hands

The most important step to prevent the spread of germs and infections is hand washing. Wash your hands often. Be sure to wash your hands each time you:

- Touch any blood or body fluids
- Touch dressings or other soiled items
- Use the bathroom
- If you are coughing, sneezing, or blowing your nose, clean your hands often. Before you eat, always clean your hands.

Here's how you should clean your hands with soap and water:

- Wet your hands and wrists with warm water.
- Use soap. Work up a good lather, and rub hard for 15 seconds or longer.
- Rinse your hands well.
- Dry your hands well.
- Use a clean paper towel to turn off the water. Throw the paper towel away.

Here's how you should clean your hands with hand sanitizers (waterless hand cleaners):

- For gel product use one application.
- For foam product use a golf-ball size amount.
- Apply product to the palm of your hand.
- Rub your hands together. Cover all surfaces of your hands and fingers until they are dry

Standard precautions

Health care workers often wear gloves, gowns, masks, or eye protection. Staff may wear some of these protective items while caring for you. This practice is called "standard precautions". This practice protects all patients and staff from germs and infections.

If you have questions

At SOMA Surgery Center our goal is for you visit be as pleasant as possible. It is important that you understand the need for hand washing and standard precautions. If you have any questions, please ask your nurse or doctor. You may also contact Infection Control if you have questions. Please tell your nurse if you want to do so.

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

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Soma Surgery Center
Beverly Hills

Infection prevention

WHAT IS A SURGICAL SITE INFECTION (SSI)?

- A surgical site infection is an infection that happens after surgery in the part of the body where the surgery took place.
- Most patients who have surgery do not develop an infection. Some of the common symptoms of a surgical site infection are:
    - Redness and pain around the area where you had surgery
    - Drainage of cloudy fluid from your surgical wound
    - Fever

AFTER YOUR SURGERY (AT HOME):

- It is normal to feel pain at the incision site. The pain decreases as the wound heals. Most of the pain and soreness from the skin incision should go away by the time the sutures or staples are removed. Soreness and pain from deeper tissues may last another week or two.
- Pain that continues more than a few weeks after surgery or pain that worsens anytime after surgery can be a sign of a complication, such as:
- Infection
- Separation of wound edges
- Collection of blood or other body fluid below the skin
- Family and friends who visit you should not touch the surgical wound or dressings. Tell them to clean their hands with soap and water or an alcohol-based hand rub before and after visiting you. If you do not see them clean their hands, ask them to do so.
- Wash your hands thoroughly after handling any type of soiled items or body fluid. This is especially important after you have used the bathroom.
- Always clean your hands before and after caring for your wound.
- If the dressing on your wound becomes loose or wet, let your healthcare providers know immediately so that it may be assessed.
- If you have any symptoms of an infection, such as redness and pain at the surgery site, drainage, or fever, call your doctor immediately.
- Follow your healthcare provider's instructions regarding deep breathing and walking. This helps prevent post-operative pneumonia, a possible complication of surgery.
- Ask your friends and relatives not to visit if they feel sick

CALL PHYSICIAN IMMEDIATELY FOR:

- Fever over 101 degrees.
- Excessive bloody wound drainage
- Yellow, green or foul smelling drainage
- A large red area around the incisions.
- Increasing pain at the site of surgery
- Redness around the wound
- Vomiting, constipation or diarrhea
- Shortness of breath or chest pain

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

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List of your Patient Rights

IN ACCORDANCE WITH HEALTH AND SAFETY CODES, THE ASC AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT RIGHTS: Our Surgery Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment, or the source of payment for his or her care.

- Considerate and respectful care and the right to exercise his or her rights without discrimination or reprisal and be free from all forms of abuse or harassment.
- Knowledge of the name of the physician who has primary responsibility for coordinating his or her care and the names and professional relationships of other physicians who will see the patient.
- Receives information from his or her physician about his or her illness, his or her course of treatment and his or her prospects for recovery in easily understood terminology.
- Receives as much information about any proposed treatment or procedure as he or she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved and knowledge of the person who will carry out the procedure or treatment.
- Participates actively in decisions regarding his or her medical care, to the extent permitted by law, including the right to refuse treatment and the right to effective pain management.
- Receives full consideration of privacy concerning his or her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to know the reason for the presence of any individual.
- Is given confidential treatment of all communications and records pertaining to his or her care and his or her stay in the ASC. His or her written permission shall be obtained before his or her medical records can be made available to anyone not directly concerned with his or her care.
- Receives reasonable responses to reasonable requests he or she may make for services.
- He or she may leave the ASC, even against the advice of his or her physicians.
- Receives reasonable continuity of care and advance knowledge of the time and location of appointment, as well as knowledge of the physician providing the care.
- Is advised if ASC/personal physician proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in any research projects.
- Will be informed by his or her physician, or a delegate of his or her physician, of his or her continuing health care requirements following his or her discharge from the Surgery Center.
- You may choose a different physician than was assigned to that patient.
- Is made aware that this facility does honor Advance Directives

For complaints or comments about your medical care, you may contact our administrator or Medical Director at 310-673-0523 or you may then contact the: **CDPH, California Department of Public Health, Division of Health Facilities Inspection, 3400 Aerojet Avenue, El Monte, CA, 91713, or your Accreditation Organization. You may also contact the Office of the Medicare Beneficiary Ombudsman at: www.medicare.gov/Ombudsman/resources.asp. If you have any questions or issues, please visit The Joint Commission Website (JCAHO), http://www.jointcommision.org/**

Patient Signature: _____ **Date**: _____ **Time**: _____

Witness Signature: _____Date: _____Time: _____

Physician Signature: _____**Date**: _____**Time**: _____

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Patient Responsibilities

As a patient in our facility, you have certain responsibilities, which include:

1. To work with your health care team and to follow all safety rules.
2. To show respect and consideration to our staff and to other patients and visitors.
3. To respect the privacy of other patients.
4. To give your health care team complete and correct information about your health.
5. To tell your doctor about any changes in your health after you leave our facility.
6. To keep, or cancel in a timely manner, your scheduled appointments for your health care.
7. To follow the directions given by your health care team after you have agreed to treatment in our facility.
8. To tell your health care team if you wish to change any of your decisions.
9. To ask for clarification if you do not understand any information or instructions given to you by your health care team.
10. This facility does honor Advance Directives.

Privacy Practices

- We may use and disclose your medical information under special restrictions.
- We may use your medical information for treatment services, payment for services.
- We may use your medical information for ongoing health care operations.
- We may use your medical information for appointment reminders, treatment alternatives and health related benefits and services.
- We may use your information if you are hospitalized and with persons involved with your care.
- We may use your medical information in disaster relief efforts or as required by law.
- We may use your medical information to avert a serious threat to your health or safety.
- We may use your medical information for possible tissue or organ donation.
- We may use your medical information related to military service, if required by law.
- We may use your medical information for Worker's Compensation benefits.
- We may use your medical information as needed for public health disclosures, health oversight activities, legal proceedings, lawsuits, and law enforcement.
- We may use your medical information as needed by coroners, medical examiners and funeral directors.
- We may use your medical information as needed for National Security, intelligence activities and for protective services of the President.
- You have the right to inspect and copy your medical information, and you may request an amendment or addendum to your medical information.
- You may request an accounting of disclosures, and you may request restrictions on the disclosure of your medical information.
- You have the right to request confidential communications concerning your medical information and you may request a paper copy of your medical information.
- You have the right to file a complaint or receive answers about your care.
- You will not be penalized for filing a complaint.

This facility is owned by Soma Orthopedic Associates.

IF YOU HAVE CONCERNS:

If you have any questions or concerns about your responsibilities, you can contact our administrator or Medical Director.

If you wish to file a complaint about your care in our facility, you may contact the following agency: CDPH, California Department of Public Health, Division of Health Facilities Inspection, 3400 Aerojet Avenue, El Monte, CA 91731 or your Accreditation Organization.. You may also contact the Office of the Medicare Beneficiary Ombudsman at the following website: www.medicare.gov/Ombudsman/resources.asp

I read and understood all of the above information

Patient Signature: _____ Date: _____ Time: _____

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Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical practice, that 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. Both 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 are 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 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 in the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdiction limit of the small claims court against the physician, and the physician' partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against 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 thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses incurred by a party for such party's own benefit. Either 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 this arbitration of any person or entity which would otherwise be a proper addition party in a court action, and upon such intervention and joinder any existing court action against such 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 disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

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 and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services. _____
Patient or Patient's Representatives Initials

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 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 YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

_____ _____
Physician's or Duly Authorized Representative's Signature & DATE Patient's Signature & DATE

_____ _____
Print or Stamp Name of Physician, Medical Group, or Association Name Print Patient's Name

_____ _____
Signature of Translator (if applicable) DATE Patient's Representative's Signature DATE

_____
Print Name and Relationship to Patient

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General Discharge Instructions

AFTER ANESTHESIA

- ALTHOUGH YOU WILL BE AWAKE AND ALERT IN THE RECOVERY ROOM, SMALL AMOUNTS OF ANESTHETIC WILL REMAIN IN YOUR BODY FOR AT LEAST 24 HOURS AND YOU MAY FEEL TIRES AND SLEEPY FOR THE REMAINDER OF THE DAY.
- DO NOT SIGN ANY LEGAL DOCUMENTS OR MAKE ANY IMPORTANT DECISIONS IN THE NEXT 24 HOURS.
- YOU MAY NOT OPERATE ANY MACHINERY OR DRIVE A VEHICLE FOR 24 HOURS AFTER YOUR SURGERY. You may drive when driving does not cause any pain. You are not allowed to drive if you are taking narcotic pain medications.
- Rest for 24 hours after the operation, it is permissible to walk around enough to take care of your basic needs but nothing more. **DO NOT** take part in any strenuous activity. This includes lifting, pushing, pulling, or straining for at least 3 weeks to 1 month. Avoid bumping or jarring in the surgical area.

DIET

- Eat light for the first 12-24 hours then resume to a well balanced diet.
- If you have any postoperative nausea, consume carbonated sodas and dry crackers, this may settle the stomach. If nausea is severe, call your surgeon. If you feel normal, stay with liquids and bland foods, and if this is well tolerated progress to a regular diet. Taking in plenty of fluids and good nourishment is essential to help your body heal properly, but keep your salt intake to a minimum.

SORE THROAT

- You may have sore throat for the first 24 hours. Drink plenty of fluid to decrease the soreness.

WORK

- Follow the plans you and your doctor agree upon.

MEDICATIONS

- Take all your recommended medications.
- **DO NOT TAKE ANY ASPIRIN, IBUPROFEN, or VITAMIN E for 2 weeks after surgery**. Tylenol is okay
- Take and finish all post- operative antibiotic prescribed to you by your physician to prevent infection. You may also receive a prescription for pain killers in the form of codeine or Hydrocodone. These products cause somnolence, drowsiness and constipation. Take the pain killer with some food or a piece of toast to reduce nausea.

ALCOHOL

- Please do no drink until you have stopped taking the pain pills, as the combination of pain pills and alcohol can be dangerous. Alcohol dilates blood vessels and could increase postoperative bleeding.

TRAVEL LIMITATIONS

- In most cases you should plan to remain within reasonable traveling distance of your doctor's office for at least the first 2 weeks.

SPECIAL INSTRUCTIONS:

- Do not remove wrap around surgical site.
- Do not wet hair or attempt to wash hair until instructed by your doctor.
- Take Deep breaths, 5 times each hour.
- Walk every 2-3 hours.
- Take pain medication and antibiotics at least 1 hour apart.

Patient Signature: _____ **Date**: _____ **Time**: _____

Witness Signature: _____ Date: _____ Time: _____

Physician Signature: _____ **Date**: _____ **Time**: _____

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8929 Wilshire Blvd. Suite 102
Beverly Hills. CA 90211
Phone: (310) 855-8936
Fax: (413) 643 6360
E-mail:info@somasurgerycenter.com
Somasurgerycenter.com

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