Jacqueline E. Jones, MD

1175 Park Avenue, Suite 1-A
New York, New York, 10128
(212) 996-2559
www.ParkAvenueENT.com

Dear Patient,

You have been scheduled for surgery at Manhattan Surgery Center located at 619 West 54th Street between 11th & 12th Avenue on

This packet contains information regarding your upcoming procedure with Dr. Jones.

✔ Information for Patients to Keep & Reference:
- Information Regarding the Packet
- Surgery Instructions

✔ Patient to Complete & Return to Office:
- Estimated Fee Agreement & Cancellation Policy
- Consent for Surgery

✔ Pediatrician to Complete & Return to Office:
- History & Physical (Medical Clearance
- ☐ CBC (Complete Blood Count) ☐ PT ☐ PTT X Covid Test in office within 5 days of procedure

✔ Resister Online:
- www.manhattansc.com
- Patient Registration Forms
- Enter Password: MSC212NEW

PLEASE NOTE:
The Medical Clearance & Patient Registration Forms must be completed:

NO LATER THAN _____
Should a delay occur, we might have to reschedule your procedure.

Please Fax All Documents to Reneé: (212) 996-2703

If you have medical or financial questions about anesthesia, please call 914-666-8866. If you need to reach Manhattan Surgery Center, please call 212-231-7778.

We are committed to making the coordination of your surgery as easy and worry free as possible.
If you have any questions at anytime, please do not hesitate to call or e-mail.
Sincerely,

Reneé Allison
Surgical Coordinator
(212) 996-2559 ext. 5
rallison@ParkAvenueENT.com

Instructions Prior to Surgery

Jacqueline Jones, MD
www.JacquelineJonesENT.com

I know that it can be very stressful preparing for surgery. The following instructions may help. After reading them carefully, please let me know if there is anything that you do not understand about the operation.

MEDICATION & VITAMINS OR SUPPLEMENTS

Two weeks before the surgery, stop using aspirin, Advil, Motrin, ibuprofen, vitamin E, vitamins, supplements, herbs or any similar drug that can cause bleeding problems. **Do not start using such drugs again until two weeks after the operation.** Use only Tylenol or Tylenol with codeine for pain. If you or your child takes any medicine on a regular basis for health reasons, let me know so we can decide whether or not it should be continued.

PREOPERATIVE TESTS

Before most operations I do require a blood test called a CBC, complete blood count. This test should be completed at least 5 days before surgery and certain operations might require a CT scan or other tests, but I will discuss this with you if necessary.

MEDICAL CLEARANCE

Your child's pediatrician must provide a complete written history and physical examination for the anesthesiologist. A special form is included in the packet and must be completed and received by my office at least 5 days (but not more than one month) before the surgery. However, it is best to bring a copy with you on the day of surgery to ensure that the operation will not be delayed.

SICKNESS

It is very common for children's surgery to be cancelled due to a cold or other infection, especially in the winter. This is mainly because the risk of anesthesia goes up if a patient has a respiratory infection. The anesthesiologist makes the final decision on the morning of surgery. While operations are not cancelled for minor symptoms, if your child is clearly sick with fever and/or a cough during the week before surgery, please check with me about rescheduling.

TIME OF SURGERY

Manhattan Surgery Center will call you the day before surgery with the time of your child's procedure.

Please realize that the length of an operation can vary due to unforeseen circumstances, and a procedure may take longer than anticipated. You should understand that each patient has to be given our full attention for safety's sake, even if it means delaying the cases that follow. Therefore, the starting time that you are given is an estimate.

EATING AND DRINKING

Children should be watched carefully before surgery, since they may try to eat or drink, which will delay or cancel their operation. This is because it is dangerous to have anything in the stomach when anesthesia is given. **CLEAR liquids**, such as water, clear jello or apple juice (not cider), or Gatorade, are OK up to three hours before the time of surgery. **Everything else (including food and milk) must not be taken for eight hours prior to the operation.**

REGISTRATION

Please arrive at Manhattan Surgery Center at least 1 hour prior to your surgery time. Manhattan Surgery Center is located at 619 West 54th Street between 11th & 12th Avenue on the 6th Floor. Their phone number is: 212-231-7778

Jacqueline Jones, MD
(212) 996-2559
www.JacquelineJonesENT.com

Parking At Manhattan Surgery Center

There is meter parking on the streets on 11th avenue.
The meter is $3.50 per hour.

Parking garages:

815 TENTH PARKING LLC
815 Tenth Avenue New York, NY 10019
Between:
11th & 10th Aves.
Phone Number
(646)414-4586

CLINTON 53 PARKING LLC
515 West 52nd Street New York, NY 10019
Between:
10th & 11th Aves
Phone Number
(212) 956-3218

Jacqueline E. Jones, MD

1175 Park Avenue, Suite 1-A
New York, New York, 10128
(212) 996-2559

Estimated Surgical Fee Agreement & Cancellation Policy

Patient Name:_____ D.O.B.:_____

Surgical Date:_____ Surgeon: Jacqueline E. Jones, MD

The following is a pre-operative estimate of surgical charges for Dr. Jacqueline E. Jones, based on the procedure planned and outlined below. Findings during surgery may necessitate different and/or additional procedures by Dr. Jones. Such changes may alter the fees which you are being quoted. If so, a Final Fee agreement will be prepared for you after the surgery by our billing department.

As with any hospital based surgery, you can expect a bill and/or statement form the hospital and Anesthesiologist for their services.

____ Dr. Jones participates with your insurance: therefore we will pre-certify the procedure(s) below and bill your carrier. As with all insurances, most plans include co-payments, deductibles and other expenses which must be paid by the patient. The responsible party will be responsible for the balance of these charges once the insurance company has paid their share. However, if your insurance is cancelled or is not in effect on the day of surgery and you neglect to inform us, you will be responsible for the full surgical fee.

____ Either you have no insurance coverage for these services or Dr. Jones does not participate with your insurance plan. Therefore payment in full is expected on the day of surgery. You may leave a credit card number or a check with the billing department that will be processed following surgery. Upon processing the payment we will forward a receipt. As a courtesy, we will bill your insurance carrier directly on your behalf. All insurance reimbursements will be sent directly to the subscriber from the insurance company.

Cancellation Policy

We reserve a specific length of time for your procedure and would greatly appreciate that any cancellations or rescheduling be done at least 5 days in advance of your procedure. If we do not receive notice that the procedure needs to be cancelled or rescheduled in advance of 5 days, we will apply a cancellation fee, in the amount of $500, to your account. We understand that unexpected and inevitable events can and will occur and ask you to inform our office as soon as possible in the event of such.

We will waive the fee if your physician or pediatrician requests a cancellation due to medical reasons.

We appreciate your cooperation and understanding regarding our policy. Should you have any questions or concerns, please do not hesitate to contact our office at 212-996-2559 x 5.

Planned Procedures(s):

CPT Code	Procedure	Fee
	Total Estimated Fee	

Acknowledgement of Responsibility

By signing this document I accept the estimated surgical fees and cancellation policy and acknowledge that the total fee may change as a result of the clinical findings during surgery, and I assume full responsibility for final payment of all surgical charges and/or cancellation fee.

_____ _____

Patient/Responsible Party Signature Date Responsibility Party Name (Print)

MANHATTAN SURGERY CENTER
619 West 54th Street, Suite 602
New York, NY 10019
(212) 231-7778 phone

CONSENT FOR SURGERY

1. Pre-Operative Diagnosis: _____

2. Proposed Procedures or Operations: _____

   _____

   _____

3. I authorize the performance upon _____ under the direction of _____ and Manhattan Surgery Center to provide treatment and perform the procedure(s) listed above which may include administration of local or topical anesthesia.

4. I further authorize other duly licensed physicians with privileges at this surgery center to perform important tasks related to the above listed procedure(s).

5. I authorized qualified medical practitioners who are not physicians to perform certain important parts of the above-listed surgery or to administer the anesthesia. Such practitioners may perform tasks, including those specified below, if they are permitted to do so under the laws of this state. All tasks performed by such practitioners will be those within the practitioner's scope of practice, for which they have been granted privileges by this surgery center and will be performed at the direction of the surgeon performing the procedure.

   Practitioner Title: PHYSICIAN ASSISTANT 1) Fulgurate simple lesions 2) Harvest vein grafts 3) Prepare bone/tendon/ligament grafts 4) Apply/adjust external fixation devices 5) Assist in placement/removal of metal fixation 6) Drill bone under guidance of surgeon.

6. The facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of the facility, but independent contractors and therefore, are the patient's agents or servants. The facility provides nursing and support services and facilities; the facility does not provide physician care.

7. The operation(s) and/or procedure(s) listed to be performed, the advantages and disadvantages, risks and possible complications, and the anesthesia risks, benefits, as well as the alternatives, and the risks, benefits and alternatives associated with performing the procedure in the ambulatory surgical facility instead of a hospital have been explained to me by my physician. The doctor has satisfactorily answered all my questions.

8. I understand that all operations/procedures involve risks and possible complications. My doctor has discussed these with me. I understand there is always the unlikely possibility of a drug or allergic reaction, bleeding, infection, nerve injury, worsened pain, numbness, headache, spinal fluid leak, pneumothorax and paralysis. These are uncommon but some of these complications may require major surgery. There is a very small risk of stroke, cardiac arrest and death. I further understand that no guarantees have been made.

9. I authorized and direct my physician to arrange for such additional services for me as deemed necessary or advisable, including but not limited to, the administration and maintenance of anesthesia, including local or topical anesthesia, and the performance of pathology and radiology services, to which I hereby consent.

10. I authorize the pathologist or physician to use their discretion in disposing of any member, organ, implant, prosthetic or other tissue removed from my person during the operation or procedure.

11. In the event of accidental exposure of my blood or body fluids to a physician, contractor or employee of the facility, I consent for testing of HIV and Hepatitis.

MANHATTAN SURGERY CENTER
619 West 54th Street, Suite 602
New York, NY 10019
(212) 231-7778 phone

12. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home following my operation/procedure. I acknowledge that I have been advised by the facility personnel not to drive until the effects of my medications have worn off. I understand this to mean that I should not drive until the day after my surgery/procedure as directed by my physician.
13. I consent to the photographing, filming, or videotaping of the treatment or procedure for diagnostic, documentation or educational use.
14. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual operation/procedure.
15. I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought to the facility.
16. I understand that if I am pregnant or there is a possibility that I may be pregnant, I must inform the facility personnel immediately.
17. I understand that my physician may have an ownership interest in the facility and I acknowledge that I have the right to have the operation/procedure performed elsewhere.
18. I understand that in the rare event that hospitalization is required during or immediately after my operation/procedure, my physician will arrange for coordination of care and my transfer to a local hospital. I consent to transfer to Mount Sinai West Hospital (or other hospital as my physician recommends) and I consent to the release of medical records between the two facilities.
19. My signature below constitutes my acknowledgement that (1) I have read or have had read to me the foregoing and I agree to it; (2) the operation(s)/procedure(s) has been adequately explained by my physician; (3) I authorize and consent to the performance of the operation(s)/procedure(s) and any additional operation(s)/procedure(s) deemed advisable by my physician in his/her professional judgment; (4) I authorize and consent to the administration of anesthesia for said operation(s)/procedure(s), as applicable.
20. If I am not the patient, I represent that I have the authority of the patient who, because of age or other legal disability, is unable to consent to the matters above. I have full right to consent to the matters above and I consent to same; I hereby indemnify and hold harmless this facility, its employees, agents, medical staff, partners and affiliates from cost or liability arising out of my lack of adequate authority to give consent.

DATE _____ PATIENT SIGNATURE OR PERSON AUTHORIZED TO CONSENT _____

RELATIONSHIP _____

DATE _____ WITNESS SIGNATURE _____

I have explained to the above named patient the nature, purpose and comparative risks, benefits and alternatives associated with the procedure(s) named above and the comparative risks, benefits and alternatives associated with performing the procedure(s) in Manhattan Surgery Center instead of in a hospital. The patient signed this form in my presence, following our discussion.

DATE _____ PHYSICIAN SIGNATURE _____

PRIMARY CARE PHYSICIAN OR INTERNIST
TO COMPLETE H&P
FAX TO: 212-996-2703

MANHATTAN SURGERY CENTER

MR #

History and Physical

Case ID #

DOS

Patient Name

DOB

Age

Sex

Surgeon

JACQUELINE JONES, MD

Chief Complaint

History of Present Illness

Review of Systems:

	Yes	No	Comments		Yes	No	Comments
GENERAL	☐	☐		SKIN	☐	☐	
HEENT	☐	☐		NEURO	☐	☐	
CVS	☐	☐		PSYCH	☐	☐	
PULM	☐	☐		ENDO	☐	☐	
GI	☐	☐		HEME	☐	☐	
GU	☐	☐		ONCO	☐	☐	
MS	☐	☐		OB / GYN	☐	☐	

Current Medications

Allergies ☐NKA

Past History

Medical

Surgical

Family History: Mother

Father

Social History: Drug

ETOH

Tobacco

Date

Time

Provider Signature

PRIMARY CARE PHYSICIAN OR INTERNIST
TO COMPLETE H&P
FAX TO: 212-996-2703

MANHATTAN SURGERY CENTER

MR #

History and Physical

Case ID #

DOS

Patient Name | DOB | Age | Sex | Surgeon

JACQUELINE JONES, MD

Constitutional

	BP	Temp	Pulse	Resp	Height	Weight
Vitals						

General Appearance

Skin	
HEENT	
Neck / Respiratory	
CVS	
Breasts	
GI	
MS / Spine	
Rectal	
GU	
Pelvic	
Extremities	
Neuro Exam	
Psych	

Labs

PATIENT WILL REQUIRE A CBC & PT/PTT
IF OVER THE AGE OF 50 AN EKG IS REQUIRED Covid test within 5 days of procedure

Impressions

Plan

Date Time

Provider Signature

Complete if H&P performed prior to admission:

☐ No change in patient condition ☐ Updated as follows

Date Time

Provider Signature

High blood pressure? ☐ YES ☐ NO Shortness of breath? ☐ YES ☐ NO

If YES, explain _____

If yes to above, name of Cardiologist: _____

Phone: _____ Last Visit: _____

Have you had a recent cough or cold, infections or fever? ☐ NO If YES, when: _____
If YES, have you been on antibiotics? ☐ NO If YES, antibiotic taken: _____

Do you have diabetes or trouble with your blood sugar? ☐ NO If YES, Insulin dependent? ☐ YES ☐ NO

Are you on Dialysis? ☐ NO, If YES, What days? M / Tu / W/Th / Fr / Sat / Su

Have you ever had a seizure? ☐ NO If YES, Explain _____

Have you ever had a stroke? ☐ NO If YES, Explain _____

Are you prone to dizziness, fainting spells, or a weakness in your arms or legs? ☐ NO If YES, date of last episode: _____

Any known blood disorders such as: **Anemia/Bleeding Disorder/DVT/PE/blood clots/Frequent nose bleeds/Easy Bruising**

☐ NO If YES, please explain _____

Blood Transfusions? ☐ NO, If YES, Explain when and why _____

Have you been diagnosed with acid reflux? ☐ NO, If YES, Explain _____

Do you snore? ☐ YES ☐ NO Do you use CPAP? ☐ YES ☐ NO

Have you had sleep studies performed? ☐ NO If YES when? _____

Have you been diagnosed with Sleep Apnea? ☐ NO If YES when were you diagnosed? _____

Past or Present history of:

Asthma	☐ NO If YES when? _____
Pneumonia	☐ NO If YES when? _____
Bronchitis	☐ NO If YES when? _____
Wheezing	☐ NO If YES when? _____
Tuberculosis	☐ NO If YES when? _____
Abnormal Chest X-Ray	☐ NO If YES when? _____
Cancer Treatment	☐ NO If YES when? _____

Any medical conditions we did not ask you about? ☐ NO
If YES, please explain: _____

Have you traveled outside of the US in the last 21 days? ☐ NO
If yes where?: _____

You must have an escort to take you home after surgery.

Escort: _____ (Relationship) _____ Telephone # _____

Mode of Transportation: _____

Emergency Contact: _____ (Relationship) _____ Telephone # _____

If you use Aspirin, Ibuprofen, Advil, Aleve, Naproxen, fish oil, or any blood thinning agents please advise your prescribing physician about your procedure.

Medical staff completing questionnaire:

Name _____ **Date:** _____

Nurse/Anesthesia Reviewing: _____ **Date:** _____

Additional Needed: Clearance: _____ **EKG:** _____ **Labs:** _____

Adult Pre-Surgical Questionnaire – LONG FORM

Surgeon's Name: _____ Procedure: _____

Patient's first name: _____ Patients last name: _____

Height: _____ Weight: _____ BMI: _____ (Last time weighed _____) Age: _____ Date of birth: _____

Date of procedure: _____ Best Telephone number to reach you: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Do you need an interpreter? If so, what language? _____

Do you have any allergies or sensitivities to drugs, dyes, any kind of tape, latex products, or any foods, etc? ☐ NO
YES Please list Allergies and reaction:

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Do you take any medicines every day? (Including, Aspirin, Birth Control Pills, Maalox etc.) ☐ NO, *If YES, Please list below:*

Medication: _____ dosage: _____ reason: _____

Medication: _____ dosage: _____ reason: _____

Medication: _____ dosage: _____ reason: _____

Medication: _____ dosage: _____ reason: _____

Medication: _____ dosage: _____ reason: _____

Medication: _____ dosage: _____ reason: _____

Medication: _____ dosage: _____ reason: _____

Medication: _____ dosage: _____ reason: _____

Do you take any herbal products, diet pills, over-the-counter products? ☐ NO, If YES, which supplements:

_____

NOTE: If you currently take herbal/diet remedies, we recommend they be stopped 1 week prior to your procedure date.

Could you be pregnant? ☐ NO, If YES, Last menstrual period: _____

Have you ever had a surgical procedure before? ☐ NO, If YES, date and type of surgery:

_____

_____

Have you ever had a problem with anesthesia? ☐ NO, if YES explain issue: _____

_____

Any physical disabilities requiring: walker wheelchair cane hearing aid oxygen other: _____

Any implants? ☐ Defib ☐ Pacemaker ☐ Stents ☐ Metal Implants; body part _____ ☐ NO

Any previous or existing heart condition? ☐ NO, If YES explain: _____

Have you ever had a heart attack? ☐ NO, If YES explain: _____

Have you experienced any of the following in the past 2 years:
Chest pain (angina)? ☐ YES ☐ NO Palpitations or irregular heart beat? ☐ YES ☐ NO