Jacqueline E. Jones, MD

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

Dear Parent,

Your child has 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 child's 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) **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 child's 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 Dr.Jacqueline E. Jones ____________ 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.

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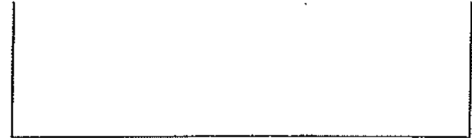

12. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home following my operation/procedure. I acknowledge that I have been advised by the facility personnel not to drive until the effects of my medications have worn off. I understand this to mean that 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**

PEDIATRICIAN 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 ______________________

PEDIATRICIAN 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

CBC and Covid Testing withing 5 days of procedure

Impressions

Plan

Provider Signature ______________________ Date Time

Complete if H&P performed prior to admission:

☐ No change in patient condition ☐ Updated as follows

Provider Signature ______________________ Date Time

Child Pre-Registration Questionnaire

Surgeon's Name: Jacqueline E.Jones 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: ______

Does your child need an interpreter? If so, what language? ______

Does your child 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: ______

Does your child take any medicines every day? ☐ NO, *if YES, Please list below:*

Medication: ______ dosage: ______ reason: ______

Medication: ______ dosage: ______ reason: ______

Medication: ______ dosage: ______ reason: ______

Medication: ______ dosage: ______ reason: ______

Medication: ______ dosage: ______ reason: ______

Does your child take any herbal products, over-the-counter products? ☐ NO, If YES, which supplements: ______

NOTE: Herbal supplements should be stopped 1 week prior to your child's procedure date.

Has your child ever had a surgical procedure before? ☐ NO, If YES, date and type of surgery: ______

______

Did they ever have a problem with anesthesia? ☐ NO, if YES explain issue: ______

______

Any Family History of Anesthesia problems? ☐ NO, if YES explain issue: ______

______

Any physical or behavioral conditions requiring special consideration? ☐ NO, if YES explain issue: ______

______

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

Name of Cardiologist: ______

Phone: ______ Date of last visit: ______

Has your child 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: ______

If YES, Date of last dose of antibiotic: ______________________

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

Has your child ever had a seizure? ☐ NO If YES, Explain ______________________

Any known blood disorders such as: Anemia / Bleeding Disorder/ Frequent nose bleeds / Easy Bruising
☐ NO If YES, please explain ______________________

Has your child been diagnosed with acid reflux, ulcers, gastritis, heartburn, hiatal hernia, regurgitation? ☐ NO If YES, Explain
____

Does your child snore? ☐ YES ☐ NO

Has your child been diagnosed with Sleep Apnea? ☐ NO If YES, when were they diagnosed?
____

Has your child had sleep studies performed? ☐ NO If YES when?
____

Birth History: ☐ Normal Birth ☐Pre-Term: __________Weeks NICU ☐ NO If YES, explain:
____

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?	______________________
Recent Tonsillitis?	☐ NO If YES when?	______________________

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

Has your child traveled outside of the US in the last 21 days? ☐ NO
If yes where? ______________________home from the

Your child must have a parent or legal guardian accompany them on day of surgery.
They must have an escort to take them home after surgery.

Escort: ______________(Relationship)______________ Telephone # ______________

Mode of Transportation: ______________________

Emergency Contact: ______________(Relationship)__________, Telephone # ______________

If your child takes Aspirin, ibuprofen, Advil, Aleve, naproxen, fish oil, or any blood thinning agents please advise your prescribing physician about their procedure.

Medical staff completing questionnaire:

Name ______________________ **Date:** __________

Nurse/Anesthesia Reviewing: ______________________ **Date:** __________

Additional Needed: Clearance: ______________, **EKG:** ______________ **Labs:** ______________