PREMIER OUTPATIENT SURGERY CENTER
900 E. WASHINGTON STREET SUITE 155 COLTON, CA 92324
(909) 370-2190 FAX: (909) 370-2266

Patient Acknowledgement of Receipt of Notices:

I, _____, have been informed of the Patient's Rights, Patient's Responsibilities, Notice of Significant Beneficial Interest, Advance Directive, and HIPAA Notice of Privacy (Green Notice). My signature indicates that I received and understand this information prior to the date of admission at Premier Outpatient Surgery Center.

_____ _____

Patient/Responsible Party Signature Date

Scheduler: To RESERVE an appointment time please call us with the following:

Surgery Date:	Appt. time:
Surgeon:	Assistant:
Pt Last Name:	Pt First Name:
Procedure:	
Procedure Duration:	Anticipated CPT codes:

☐ C Arm ☐ Mini C Arm ☐ Laser ☐ 23 hr hold Anesthesia: ☐ General, ☐ MAC, ☐ Local, ☐ Regional
☐ Pathology ☐ Pathologist present at the time of the procedure
☐ Other special equipment (specify):

For Confirmation of booking, please fax the following information by the end of the same business day:
(Non-receipt may cause cancellation)

☐ **Surgery Reservation Form**
☐ **Patient demographics** (Full name, address, telephone #, DOB, SS#)
☐ **Patient insurance information** (A CLEAR copy of insurance card or computer print out)
☐ Other information required by your doctor, ie. MRI

Name of physician performing pre-op H&P: ☐ Surgeon ☐ Other (specify)	Telephone #:
Name of laboratory performing pre-op Labs:	Telephone #:
Pre-op ICD9:	
Notes:	

Please also fax the following information no later than the day before surgery:

☐ **POSC Physician's Orders** (Minimum=Pre-op orders)
☐ **History & Physical signed by surgeon or primary source**
☐ **Pre-op lab results** (if applicable)