Jeffrey S.
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Surgery Scheduling Inquiry

Your medical coverage is a contract between you and your insurance company. As the policyholder you should be aware of the requirements and limitations of your plan. Prior to surgery, please check with your insurance company concerning your responsibility. A customer service number is often found on the insurance card provided by your company. If accurate information is not obtained your insurance company could reject your claim or pay at a reduced rate. **If you have a deductible that has not been met, we will ask that you pay that in advance of the surgery being scheduled.**

WE WILL NOT SCHEDULE THE SURGERY UNTIL THIS FORM IS SIGNED AND RETURNED TO OUR OFFICE WITH PAYMENT (IF REQUIRED).

PROCEDURE PLANNED (if known) _____

PATIENT NAME _____

POLICY HOLDER NAME _____

INSURANCE COMPANY _____

INSURANCE BILLING ADDRESS _____

MEMBER/POLICY ID# _____

POLICY GROUP # _____

PREFERRED FACILITY (determined by insurance company)

_____ AKRON CHILDREN'S HOSPITAL MAIN OR
_____ AKRON CHILDREN'S HOSPITAL OUTPATIENT SURGERY CTR
_____ AKRON CITY HOSPITAL
_____ AKRON GENERAL HOSPITAL MAIN
_____ AKRON GENERAL HOSPITAL HEALTH & WELLNESS

I have read the above and fully understand. I agree to accept financial responsibility for any services provided by JEFFREY S. MASIN, MD.

SIGNATURE_____DATE_____

Please list three dates that are good for scheduling your surgery (Tuesday/Thursday):

1._____ 2._____ 3._____

Pre-Registration Form for Surgery Procedure

Patient Information:

Patient's Legal Name

Last Name:_____First Name:_____M.I._____

Date of Birth:_____ Gender: □ Male □ Female

Language Spoken:_____ Marital Status:_____

Legal Guardian/Guarantor:

Last Name:_____First Name:_____M.I._____

Best Phone Number to Call:_____

Home: _____ Times Available:_____

Work:_____ Times Available:_____

Cell:_____ Times Available:_____

Relation to Patient:

□ Parent □ Foster Parent □ Self □ Other:_____

□ Children's Services Board (CSB) County Name:_____

Akron Children's Hospital

Y	N	Akron Children's Hospital OSC Primary Screening Form
		1. Has the patient ever been hospitalized for more than one day?
		2. Has the patient ever required unplanned hospitalization after surgery or procedure requiring anesthesia or sedation?
		3. Has the patient or immediate family member had a reaction to or complication from anesthesia OTHER THAN nausea/vomiting or slow to wake up?
		4. Does the patient have any medical condition(s) requiring ongoing care with a health care provider?
		5. Has the patient had a respiratory illness within the past 2 weeks?
		6. Any brother or sister suffer SIDS (sudden infant death syndrome) or another unexplained death?
		7. Is BMI % for age > 95%?

Please circle appropriate answer for evaluation of primary screening process:

Primary Screening status	**PASS**	**FAIL**
Surgical location deemed by surgeon	**OSC**	**Main hospital**

NOTES:

***If all answers are no:**

Patient is a candidate for OSC and may:

1) Have OSC surgery scheduled
2) Schedule PSP appointment (same day or in future per patient preference)

****If any answer is yes, clinic can chose:**

1) Clinic office may schedule surgery for MAIN OR and schedule PSP appointment
2) Clinic office may utilize OSC secondary screen and OSC exclusion guidelines to determine if patient is OSC candidate
3) If surgeon/designee remains uncertain as to appropriate location for surgery, contact PSP screening team for guidance at (330) KIDS-PSP/(330) 543-7777.

The design of Primary Screen is to be extremely sensitive and detect inappropriate OSC patients. It should be understood some patients that ***may*** be OSC candidates ***will*** be flagged via the primary screen. When this occurs, the surgeon/designee should thoughtfully elicit additional history and utilize the additional tools provided, including OSC Secondary Screen and OSC Exclusion Guidelines to determine OSC candidacy.

Signature: _____ Date: _____ Time: _____

****Fax this form to (330) 543-7874 (KID-SURG)**