



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 at least 7 days before surgery.**

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
- \_\_\_\_\_ SUMMA 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. \_\_\_\_\_

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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)**