

# Allen Kamrava MD MBA

BOARD CERTIFIED GENERAL & COLORECTAL SURGEON

## **Procedure Information Sheet**

Admit Date/Procedure Date: \_\_\_\_\_

Hospital / Surgical Center: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Procedure Time: You will receive a call one business day before your procedure providing you the estimated procedure start time.

Arrival Time: One hour prior to procedure time.

Instructions: Do not eat or drink anything after midnight before your procedure.

Bowel Preparation: Depending on your procedure, you will have one of the following:

1. Full bowel preparation
2. Enema bowel preparation
3. No preparation

Transportation: You will not be able to drive yourself home after your procedure. Please arrange for transportation accordingly. Due to liability concerns, you will not be released to the care of a taxi as a mode of transportation.

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## **Informed Consent**

1. I hereby authorize Allen Kamrava, M.D. and/or such assistants and associates as may be selected by him to perform the following procedure(s)/treatment(s) upon myself/the patient.

Procedure(s)/Treatment(s)

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2. I understand that this procedure(s)/treatment(s) appears indicated by the diagnostic and/or clinical observations performed. I have been informed of the following:
  - A description of the proposed procedure/treatment
  - The indications for the proposed procedure/treatment
  - Material risks and benefits for the patient related to the treatment based on the available clinical information and dependent upon the professional custom and standard.
  - The likelihood of the patient achieving his or her goals.
  - Treatment alternatives, including the attendant material risks and benefits
  - The probable consequences of declining the recommended or alternative therapies
  - Who will provide the procedure/treatment
  - When indicated, any limitations on the confidentiality of information learned from or about the patient
3. I understand the information provided and give this consent voluntarily.
4. I authorize the administration of blood and blood products to myself/the patient as may be considered necessary or advisable in connection with the above described procedure(s)/treatment(s) both during the procedure and for the remaining period of hospitalization of myself/the patient. I have been informed of the potential benefits, risks or alternatives to receiving blood and blood products.

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5. I authorize the administration to myself/the patient of anesthetics determined to be necessary or advisable by the physician responsible for administering or for supervising the administration of anesthetics. I acknowledge that I have been fully advised about, and understand, the nature and purpose of the anesthesia, the possible risks and complications and possible alternative anesthesia methods.
6. I have informed the licensed health care provider that to my knowledge I have allergies to the following substances and drugs: (If none, leave blank)  

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7. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/treatment(s).
8. I consent to the photographing or televising of the procedure(s)/treatment(s) to be performed, including appropriate portions of my/the patient's body, for medical, scientific or educational purposes, provided my/his/her identity is not revealed by the pictures or by descriptive texts accompanying them.
9. For the purpose of advancing medical education, I consent to the admittance of observers to the room in which the procedure(s)/treatment(s) is performed. Such observers may be health care professionals, students, clinical device specialists or others as may be identified by my physician/health care provider.
10. I consent to the disposal by Medical Center authorities of any tissues or body parts which may be removed.
11. I acknowledge that I have read and fully understand this document and that if I have questions I have had the opportunity to have them answered by the physician/health care provider.

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## Patient Rights and Notification of Physician Ownership

YOU HAVE THE RIGHT TO RECEIVE THE FOLLOWING INFORMATION IN ADVANCE OF THE DATE OF YOUR PROCEDURE.

### **PATIENT BILL OF RIGHTS:**

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL WITH HIS/HER RIGHTS RESPECTED. Allen Kamrava, M.D. M.B.A AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT RIGHTS.

### **PATIENT RIGHTS:**

1. To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
2. To be treated with respect, consideration, and dignity in receiving care, treatment, procedures, surgery, and/or other services.
3. To be provided privacy and security of self and belongings during the delivery of patient care services.
4. To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
5. To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.
6. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.
7. To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If the treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
8. To be free from mental and physical abuse, free from exploitation, and free from use of restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.
9. Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discretely.
10. Confidential treatment of all communications and records shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.

11. To leave the facility even against the advice of his/her physician.
12. Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
13. Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.
14. To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.
15. To know which facility rules and policies apply to his/her conduct while a patient.
16. To have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.
17. To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. The patient's written consent for participation in research shall be obtained and retained in his/her patient record.
18. To examine and receive an explanation of his/her bill regardless of source of payment.
19. To appropriate assessment and management of pain.

### **If you need a Translator:**

If you will need a translator, please let us know and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

### **Rights and Respect for Property and Person**

#### ***The patient has the right to:***

- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievance regarding treatment or care that is, or fails to be, furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality or personal medical information.

### **Privacy and Safety**

#### ***The patient has the right to:***

- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment

### **Advance Directives**

An "Advanced Directive" is a general term that refers to your oral and written instructions about your future medical care, in the event that you become unable to speak for yourself. Each state regulates the use of advanced directives differently. There are two types of advance directives: a living will and a medical power of attorney. If you would like more information regarding advance directives in CA, visit: [http://ag.ca.gov/consumers/general/adv\\_hc\\_dir.php](http://ag.ca.gov/consumers/general/adv_hc_dir.php)

### **Submission & Investigation of Grievances**

Persons who have a concern or grievance against Allen Kamrava, M.D. but not limited to, decisions regarding admission, treatment, discharge, denial of services, quality of services, courtesy of personnel or any other issues are encouraged to contact your state representative to file a formal complaint:

California Department of Public Health  
PO Box 997377, MS 3000  
Sacramento, CA 95899-7377

### **Physician Financial Interest & Ownership:**

LaPeer Health Center and Surgical Center is owned, in part, by the physician. The physician who will be performing your procedure has a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at the designated center.

Signature of Patient or Legal Representative

Date \_\_\_\_\_

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## **Freedom of Choice: Understanding Your Out of Network Benefits**

Health insurance can be a daunting and confusing topic for many patients. There are many misconceptions related to how your insurance works at an Ambulatory Surgery Center (ASC) like La Peer Surgery Center. We hope to clarify some of your questions here. If we have missed anything, please do not hesitate to contact us.

### **Frequently Asked Insurance and Billing Questions**

#### **My surgeon referred me to a surgery center that is an out-of-network facility. What does this mean?**

*Insurance carriers often refer to our surgery center as an “Out Of Network” facility, much like other specialty clinics in medicine. This does NOT mean we do not accept your insurance rather that we enter into a reimbursement contract with your particular health insurance provider. However, if you have an insurance policy with Out of Network benefits (ie. a PPO policy), you have the additional benefit of visiting physicians and surgical facilities that are outside of our “network.”*

#### **What are the benefits of going to an Out-of-Network surgical facility?**

*Many people choose a PPO policy because it generally provides the most flexibility to the insured, thus allowing the ability to make the most optimal health care choices when compared to an HMO policy. The extra premium that is paid for a PPO allows for the freedom of choice. Your surgeon has recommended our facility to you because it is the ideal setting for your outpatient procedure. By having the procedure done at our facility, you are avoiding an unnecessary, costly and sometimes lengthy hospital stay. Our facility has all of the essential and advanced technology, equipment and experienced staff that will be available to you based on your specific procedure and customized needs of you and your surgeon.*

#### **Will my insurance company penalize me in any way for visiting a surgical facility outside of my network?**

*We have determined that your PPO policy allows you to use our outpatient facility. However, in order to maximize profits, your insurance carrier is motivated to discourage you from using your out-of-network facilities. They may warn you that you may be responsible for a larger percentage of the surgical facility fees, however this does not necessarily mean that YOU will pay more. Remember, ambulatory surgical centers are able to do what hospitals do, however for a fraction of the cost. In fact, with a typical outpatient procedure you will often find that you will actually pay significantly less out of pocket by utilizing our facility and your out-of-network benefits.*

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## Will it cost me more to have my surgery at an out of network facility?

Using an out of network doctor or surgery center simply means that you are seeking medical care outside of our insurance company's network. As a result, your insurance company will cover a smaller portion of the total costs versus going to an in-network hospital.

However, compared to an in-network hospital (which bills MUCH more in order to cover its high overhead), a surgical center can charge substantially less for its procedures, resulting in a lower out of pocket cost for you.

**TYPICAL OUTPATIENT PROCEDURE\***

	In-Network Hospital	VS.	Out-of-Network Surgery Center
Insurance Covers	80%		60%
Patient Covers	20%		40%
Procedure Cost	\$60,000		\$22,500
Insurance Pays	$\$60,000 \times 80\% = \$48,000$		$\$22,500 \times 60\% = \$13,500$
Patient Pays	$\$60,000 \times 20\% = \$12,000$		$\$22,500 \times 40\% = \$9,000$
Patient Savings			25% less than in-network

\*Assumes deductible has been satisfied.

Ambulatory surgical centers choose to remain "Out of Network" with most insurance carriers in order to maintain flexibility and to provide the most optimal treatment options for their patients. By doing this, the facilities can tailor operations to suit specific surgeries, surgeons and most importantly, their patients.

In contrast, in-network providers are contractually obligated regarding where, when, how and by whom certain surgeries are authorized to be performed. Our goal is for you and your surgeon to have options as to how best to treat your condition.

## What kind of bills and statements can I expect to see after my visit to the surgery center?

After your surgery, you will receive a statement called an "Explanation of Benefits" (EOB), which simply itemizes the fees charged and the allowable amount covered by your insurance company. After receiving the EOB, you will subsequently receive bills from several offices: your surgeon, your anesthesiologist (if applicable), and from us, the surgery center. Consistent with the EOB, our surgery center's bills will show the amounts you are responsible for, as determined by your particular PPO insurance policy, less any payments you've already made.