Manalapan Surgery Center
Required Documents for Privileging Application

- Resume/CV
- Copy of Diver's License or other form of Acceptable Photo Identification
- Completed & Signed Application (Attached), listing of procedures doctor intends on performing
- Any awarded Medical Licenses and/or Certificates of Training (i.e. University Degree, Fellowship, Board Certification Letter)
- Two (2) Peer References (sample included)
- Copy of NJ License
- Copy of DEA
- Copy of CDS
- Copy of Malpractice Insurance
- Delineation of Privileges from a Hospital or ASC approving same/similar procedures
- Preference Card listing preferred supplies and/or equipment/reps required for OR cases
- Latest History & Physical, within 1 year (sample included)
- Titers/Vaccines for Measles, Rubella, Varicella, Hepatitis B
- Proof of Flu Vaccine
- 2 Step PPD (both performed within 1 year) and current PPD
- ACLS and BLS certificates current (required if Anesthesiologist)
- Signed Disclosure for Background Information

When **all** documentation is received, we will then conduct a NPDB search, license verification, NPI search and documentation will be submitted for Board review and approval.

The entire process normally takes approximately 2 weeks.

Thank you very much for your interest in our Facility!
Any questions please do not hesitate to call & speak with me.

Annette Paxton

Telephone: 732-617-5990
Fax: 732-909-2288
Email: apaxtonmsc@gmail.com

MANALAPAN
SURGERY CENTER

DELINEATION OF PRIVILEGES
PRACTICE AREA: **CHIROPRACTOR**

CHIROPRACTOR PRIVELEGES – I am requesting Chiropractor privileges for:

Requested	Deferred	Granted	Procedure
☐	☐	☐	Manipulation Under Anesthesia

I agree to admit patients, perform histories and physicals, order diagnostic tests, request consultations, provide consultations within the scope of my privileges, use all skills normally learned during medical school and residency, and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the Facility.

I will practice within the bounds of my training and competence and will not attempt to treat cases which are not in my scope of practice. I understand that any newly developed treatment modalities are not included in this request and must be cleared by the medical executive Committee and Governing Board before their performance. I will become familiar with the capabilities and limitations of this Facility.

I understand that in making this request I am bound by the applicable Bylaws and/or Policies & Procedures of *Manalapan Surgery Center*, and hereby stipulate that I meet the threshold criteria for this request. I also certify that I have knowledge to operate all the equipment necessary to carry our requested procedures.

Date: _____

Printed Name: _____ Physician's Signature: _____

If Deferred Explanation required: _____

Governing Body Approval Date: _____

President, Governing Body: _____

MANALAPAN SURGERY CENTER

50 Franklin Lane
Suite 101
Manalapan, NJ 07726
Phone 732-617-5990 Fax 732-909-2288

INITIAL APPLICATION FOR MEDICAL STAFF APPOINTMENT

PLEASE PRINT OR TYPE

Name: _____ **Date:** _____

Specialty: _____

Office: _____ **Cell:** _____

Business Address: _____

Home Address _____

Email: _____

SS #: _____ **DOB:** _____

Tax ID#: _____ **NPI#:** _____

EDUCATION:

College: _____

Degree: _____

Date of Graduation: _____

Medical School: _____

Internship: _____

Dates: _____

Residency: _____

Dates: _____

Specialty: _____

Fellowship: _____

Dates: _____

Specialty: _____

MANALAPAN SURGERY CENTER
50 Franklin Lane
Suite 101
Manalapan, NJ 07726
Phone 732-617-5990 Fax 732-909-2288

MEMBERSHIPS/APPOINTMENTS:

Current Hospital Appointments: _____

Board Certification: _____

Specialty: _____

Comments/List: _____

_____

_____

MANALAPAN SURGERY CENTER

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Phone 732-617-5990 Fax 732-909-2288

IF ANSWERS TO ANY OF THE FOLLOWING QUESTIONS IS "*YES*"
PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER

1. Has your license to practice medicine been voluntarily or involuntarily limited, suspended, revoked or restricted.....YES/NO

2. Has your license to prescribe narcotics been voluntarily refused, suspended or revoked.....YES/NO

3. Have you relinquished or reduced your privileges at any hospital or surgery center.....YES/NO

4. Have you ever been denied requests for privileges at any hospital or surgery center.....YES/NO

5. Have you ever resigned or been asked to resign from a Medical Staff or a professional society.....YES/NO

6. Has any hospital or surgery center ever suspended, diminished, revoked, or failed to renew your privileges.....YES/NO

7. Have you eever been convicted of a crime (other than a motor vehicle citation).....YES/NO

8. Have you ever been denied membership or renewal therof, or been subject to disiplinary proceedings in any medical organization.....YES/NO

9. Have you ever had professional liability insurance denied, cancelled, issued on special terms or renewal refused.....YES/NO

10. Do you have any malpractice claims pending.....YES/NO

11. Do you have any physical or mental limitations that will impair your ability to render quality medical care.....YES/NO

12. Have you had any malpractice judgments or settlements made against you.....YES/NO
If *yes*, describe the date and nature of the alleged malpractice, name of insurance company defending you, settlement amount if settled, judgment amount or verdict if case went to trial, current status if case is not resolved

Signature **Date**

Practitioner Data Record/Authorization and Liability Release Form
Please Read Carefully Before Signing

General Provisions:
In order to evaluate my application, I agree to the following terms and conditions:

1) That the information contained in the Practitioner Data Record is true and accurate and that information important to my application has not been falsified and/or omitted intentionally.

   I fully understand that any misstatements or omissions from this application constitute cause for denial of appointment.

   I understand that this is an application process and does not constitute acceptance or approval by a credentialing committee; I also acknowledge that my cooperation by consenting to the production of such information about me does not guarantee that Manalapan Surgery Center and its affiliates will contract with me as a provider of services. I further understand that the burden of providing the necessary information to process my application is upon me (the applicant).

2) I give full permission and authorization to Manalapan Surgery Center to collect, research, and verify any and all references, licenses, certificates, insurance related matters, appointments, and such matters that relates to consideration of my application. This permission extends to and includes the current application and periodic checks as required by the credentialing institution, NJ, HRS, AHCA Prepaid Health Plan, NCQA, JCHAO and/or AAAHC and for re-credentialing. The aforementioned shall be in effect as long as the applicant is affiliated with the credentialing institution.

3) I hereby release from liability and hold harmless all employees, previous employees, staff, authorized representatives, management and affiliates of all institutions or groups for all acts and segments made in connection with collection, verification, review, and evaluation of my credentials and qualifications. These institutions, individuals, and groups include but are not limited for:
   a. Manalapan Surgery Center
   b. Educational Institutions
   c. Previous employees
   d. Public or private record providers
   e. Interviews
   f. Governmental and non-governmental agencies
   g. Insurance Companies

   The forgoing immunities form liability shall be in addition to those provided by law.

4) I, the undersigned, agree to waive any written notice from any present or past organization, individual, or employer that prohibits release of information important to my application.

5) I, the undersigned, agree to accept a "faxed" or photocopy of this authorization to be accepted with the same authority as the original.

_____
Applicant Signature

_____ _____
Applicant Printed Name Date

THE MANALAPAN SURGERY CENTER

Practitioner Peer Reference

(Name of Organization)

(Street Address)

(City, state, zip code)

RE: Applicant Name & Title

Dear Sir or Madam:

The above practitioner has applied for medical staff appointment (or clinical privileges) to the staff of Manalapan Surgery Center. The applicant has given your name as reference, and we are asking you to render an opinion in the following categories. This is an important part of the evaluation of this practitioner's application for surgical privileges. Your response will be treated as confidential.

Please do not hesitate to call us if you feel your comments could be best expressed directly.

Clinical Knowledge	☐ reliable	☐ usually reliable	☐ problems
Clinical Judgment	☐ reliable	☐ usually reliable	☐ problems
Technical Proficiency	☐ reliable	☐ usually reliable	☐ problems
Professional Relations w/Patients	☐ reliable	☐ usually reliable	☐ problems
Ethical Conduct	☐ reliable	☐ usually reliable	☐ problems
Record keeping	☐ reliable	☐ usually reliable	☐ problems
Ability to understand & speak English	☐ reliable	☐ usually reliable	☐ problems
Participation in Medical Staff Affairs	☐ reliable	☐ usually reliable	☐ problems

What is your opinion regarding competency in performing their procedures?

Additional Comments:

Recommendation:

Signature Title Date

Name (please print)

THE MANALAPAN SURGERY CENTER

Practitioner Peer Reference

_____
(Name of Organization)

_____
(Street Address)

_____
(City, state, zip code)

RE: _____
Applicant Name & Title

Dear Sir or Madam:

The above practitioner has applied for medical staff appointment (or clinical privileges) to the staff of Manalapan Surgery Center. The applicant has given your name as reference, and we are asking you to render an opinion in the following categories. This is an important part of the evaluation of this practitioner's application for surgical privileges. Your response will be treated as confidential.

Please do not hesitate to call us if you feel your comments could be best expressed directly.

Clinical Knowledge	☐ reliable	☐ usually reliable	☐ problems
Clinical Judgment	☐ reliable	☐ usually reliable	☐ problems
Technical Proficiency	☐ reliable	☐ usually reliable	☐ problems
Professional Relations w/Patients	☐ reliable	☐ usually reliable	☐ problems
Ethical Conduct	☐ reliable	☐ usually reliable	☐ problems
Record keeping	☐ reliable	☐ usually reliable	☐ problems
Ability to understand & speak English	☐ reliable	☐ usually reliable	☐ problems
Participation in Medical Staff Affairs	☐ reliable	☐ usually reliable	☐ problems

What is your opinion regarding competency in performing their procedures?

_____

_____

_____

_____

Additional Comments:

_____

_____

Recommendation:

_____

_____
Signature Title Date

_____
Name (please print)

MANALAPAN SURGERY CENTER

50 Franklin Lane, Suite 101
Manalapan, NJ 07726

Patients Name: **DOB:**	

Planned Procedure: _____

HISTORY

Chief Complaint: _____

Diagnosis: _____

Allergies: ☐NONE ☐LATEX

☐OTHER: _____

Medical History: _____

Surgical History: _____

CURRENT MEDICATIONS & DOSAGES

SOCIAL HISTORY

Smoking	☐ NO ☐YES ☐CURRENT _____ ☐HISTORY _____
Alcohol	☐ NO ☐YES ☐QUANTITY _____
Recreational Drugs	☐ NO ☐YES ☐CURRENT _____ ☐HISTORY _____

PHYSICAL EXAMINATION

GENERAL: _____

Mental Status	☐WNL ☐VARIANCE _____
NEUROLOGICAL	☐WNL ☐VARIANCE _____
HEAD & NECK	☐WNL ☐VARIANCE _____
ENT	☐WNL ☐VARIANCE _____
CARDIAC	☐WNL ☐VARIANCE _____
PULMONARY	☐WNL ☐VARIANCE _____
VASCULAR	☐WNL ☐VARIANCE _____
GI	☐WNL ☐VARIANCE _____
URO/GENITAL	☐WNL ☐VARIANCE _____

OTHER: _____

MEDICALLY CLEARED: ☐YES ☐NO ☐N/A

PHYSICIAN SIGNATURE: _____ **PRINT NAME:** _____

DATE: _____ **TIME:** _____

***Physician performing must check and document immediately prior to procedure.**

☐No changes in patient status from above H&P

☐Note Changes: _____

☐H&P Reviewed; Date____/____/_____ BASED UPON MY EXAMINATION_____ WITH NO CHANGE_____

MD SIGNATURE

☐H&P Reviewed; Date____/____/_____ BASED UPON MY EXAMINATION_____ WITH NO CHANGE_____

MD SIGNATURE

THESE ARE THE FOLLOWING CHANGES:

_____

_____

_____

_____

PHYSICIAN SIGNATURE: _____ **DATE:** _____ **TIME:** _____

MANALAPAN SURGERY CENTER
Confidentiality Agreement

I understand that the MANALAPAN SURGERY CENTER has a legal and ethical responsibility to maintain patient privacy, including obligation ro protect the confidentiality or patient information and to safeguard the privacy information.

In addition, I understand that during the course of my employment/assignment/affiliation at MANALAPAN SURGERY CENTER, I may see or hear other confidential information such as financial data and operational information pertaining to the practice that MANALAPAN SURGERY CENTER is obligated to maintain as confidential.

By signing this document I understand and agree that:

- I will disclose Patient Information and/or Confidential Information only if such disclosure complies with policies, and is required for the performance of my job.
- My personal access code(s), user ID(s), access key(s), and password(s) used to access computer systems or other equipment are to be kept confidential at all times.
- I will not discuss any information pertaining to the practice in an area where unauthorized individuals may hear such information (for example: in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, and at social events). I understand that it is not acceptable to discuss any Practice information in public areas even if specifies such as a patient's name is not used.
- I will not make inquiries about any practice information for any individual or party who does not have proper authorization to access information.
- I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purging of patient information or confidential information. Such unauthorized transmissions include, but are not limited to removing and/or transferring patient information or confidential information from computer system to unauthorized locations (for instance, home).
- Upon termination of my employment/assignment/affiliation, I will promptly return all documents, ID badges, etc. to the practice.

I agree that my obligations under this agreement regarding Patient Information will continue after the termination of my employment/assignment/affiliation with the Practice.
I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my employment/assignment/affiliation with the Practice and/or suspension, restriction, loss of privileges, in accordance with MANALAPAN SURGERY CENTER policies, as well as potential personal civil and criminal legal penalties.

I understand that any confidential information or patient information that I access or view does not belong to me.

I have read the above agreement and agree to comply with all its terms as a condition of continuing employment.

_____
SIGNATURE

_____ _____
PRINT NAME DATE

MANALAPAN SURGERY CENTER

I am applying for privileges to the Medical Staff of MANALAPAN SURGERY CENTER.

I have read and agreed to abide by the bylaws, rules, regulations, and MANALAPAN SURGERY CENTER policies, as now written and as may be updated and revised in the future. I understand that any misstatement or misrepresentation by myself can result in immediate denial of privileges.

I agree to maintain professional liability insurance and to provide MANALAPAN SURGERY CENTER with a copy of all renewed or new certificates.

I hereby authorize MANALAPAN SURGERY CENTER to consult or inquire about my credentials and all information provided on this application.

I hereby certify that I have no disabling mental or physical disability of sufficient severity to prevent myself from providing for my patient competently. I agree to report any changes in my physical or mental health that would interfere with my duties.

I hereby apply for appointment to the medical staff of the MANALAPAN SURGERY CENTER. I agree to abide by all the rules and regulations of the medical staff and the current policies and those who may be amended in the future. I also give permission for MANALAPAN SURGERY CENTER to make inquiries about my credentials and I release those organizations from liability.

_____, MD / DO
PHYSICIAN SIGNATURE

_____ _____
PRINTED PHYSICIAN NAME DATE

MANALAPAN SURGERY CENTER

Application Agreement and Authorization

As an applicant for privileges to the Medical Staff, I agree with the following:

- I understand that any misstatement or misrepresentation by myself can result in immediate denial of privileges.
- I will report any changes in my physical or mental health that would preclude me form my duties.
- I will maintain professional Liability Insurance and to provide the Center with a copy of all renewed or new policies.
- I also release from liability all individuals and organizations, including this Center, who provide information on myself in good faith at the request of the Center in order to verify my qualifications for appointment to the medical staff and granting of privileges.
- I hereby certify that I have no disabling mental or physical disability of sufficient severity that prevents me from providing competent care.
- I hereby apply for appointment to the Medical Staff of Surgery Center. I agree to abide by all the rules and regulations of the medical staff and the current policies that are applicable to my particular appointment on the staff. I also give permission for Manalapan Surgery Center to make inquiries about any information on my application and my credentials.

Name (Print): _____

Signature: _____

Date: _____

Candidate Disclosure, Authorization & Consent for the Procurement of Consumer Reports

Section I: Disclosure

MANALAPAN SURGERY CENTER (the "Company") may request background information about you from a consumer reporting agency in connection with your employment application and for employment purposes. The report ordered is defined by the Fair Credit Reporting Act (FCRA) as a Consumer Report, and all inquiries are limited to information that affects job performance and the workplace. It is conducted in accordance with applicable federal and state laws including the FCRA. The screening will be conducted by an outside agency — **GoodHire, LLC. – P.O. Box 391146 Omaha, NE 68139 | 1-888-906- 7351 | support@goodhire.com**. As a result, GoodHire may obtain a Consumer Report on you as an applicant or during employment.

A consumer report is a compilation of information that might affect your employability. The scope of the report may include information concerning your driving record, civil and criminal court records, credit, worker's compensation record, education, credentials, identity, past addresses, social security number, previous employment and personal references.

Should an employer rely upon a consumer report for an adverse action, the FCRA mandates you be provided with a copy of the consumer report and a summary of your rights. An adverse action is defined as "a denial of employment or any other decision for employment purposes that adversely affects any current or prospective employee."

Section II: Authorization and Release

I have carefully read and understand this Candidate Disclosure, Authorization & Consent for the Procurement of Consumer Reports form and the attached summary of rights under the Fair Credit Reporting Act. By my signature below, I consent to the release of consumer reports and investigative consumer reports prepared by a consumer reporting agency, such as GoodHire, LLC., to the Company and its designated representatives and agents. I understand that if the Company hires me, my consent will apply, and the Company may obtain reports, throughout my employment. I also understand that information contained in my job application or otherwise disclosed by me before or during my employment, if any, may be used for the purpose of obtaining consumer reports and/or investigative consumer reports. By my signature below, I authorize law enforcement agencies, learning institutions (including public and private schools and universities), information service bureaus, credit bureaus, record/data repositories, courts (federal, state and local), motor vehicle records agencies, my past or present employers, the military, and other individuals and sources to furnish any and all information on me that is requested by the consumer reporting agency. By my signature below, I certify the information I provided on this form is true and correct and will be valid for any reports that may be requested by or on behalf of the Company.

☐ **I authorize GoodHire and its agents to contact my current employer if necessary to verify my current employment status.**

Applicant Name: _____ **Applicant Email:** _____

Applicant Signature: _____ **Date:** _____

If you are resident of, or performing jobs located in, California, Minnesota, Oklahoma, Massachusetts or New York, you can receive a free copy of any Consumer Report, Investigative Consumer Report or Credit Report by contacting GoodHire at 1-888-906-7351 or support@goodhire.com.

Section III: Additional State Law Notices

If you reside in, or are seeking work in any of the following states, please review these additional notices:

California: You have the right to view your file that a Consumer Reporting Agency holds. By providing proper identification and duplication cost, you may obtain a copy of this information in person at the Consumer Reporting Agency's regular business hours and after providing reasonable notice for your request. Additionally, you can make the same request via mail or over request a summary of the file over the phone. The Consumer Reporting Agency can assist you in understanding your file, including coded information. You are allowed to have one additional person accompany you so long as they provide proper identification.

Maine: You have the right to ask and know whether a company ordered a background check on you. You can request the name, address, and telephone number of the nearest Consumer Reporting Agency office. Your request will be processed and sent to you in 5 business days.

Massachusetts: You have the right to obtain a copy of any of your consumer reports that your company has ordered on you by contacting the Consumer Reporting Agency for a free copy.

New York: By submitting a written request, you can learn whether a company has run a background check on you. You are allowed to inspect and order a copy of the report by directly contacting the Consumer Reporting Agency. If you have been convicted of one or more criminal offenses, you can request the company to provide a written statement declaring the reasons for the refusal of hire. This statement must be provided to you within 30 days of your request.

Washington State: After submitting a written request and waiting a reasonable amount of time after receiving the disclosure, you have the right to receive a complete and accurate disclosure of the nature and scope of any "investigative" consumer reports requested by an agency. The Washington Fair Credit Reporting Act requires Consumer Reporting Agencies to provide you a summary of your rights and remedies upon request. Any information requested by a company that deals with credit worthiness, credit standing or capacity is justified in order for employers to evaluate whether you present a risk for theft or dishonest behavior for the job you are being considered for.

Section IV: A Summary of Rights Under The FCRA

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to http://www.ftc.gov/credit **or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, DC 20580.**

• **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address and phone number of the agency that provided the information.

• **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a Consumer Reporting Agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

- A person has taken adverse action against you because of information in your credit report;
- You are the victim of identify theft and place a fraud alert in your file;
- Your file contains inaccurate information as a result of fraud;
- You are on public assistance;
- You are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See http://www.ftc.gov/credit for additional information.

• **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

• **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate and report it to the Consumer Reporting Agency, the agency must investigate unless your dispute is frivolous. See http://www.ftc.gov/credit for an explanation of dispute procedures.

• **Consumer reporting agencies must correct or delete inaccurate, incomplete or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

• **Consumer reporting agencies may not report outdated negative information.** In most cases, a Consumer Reporting Agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

• **Access to your file is limited.** A Consumer Reporting Agency may provide information about you only to people with a valid need - usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

• **You must give your consent for reports to be provided to employers.** A Consumer Reporting Agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to http://www.ftc.gov/credit.

• **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.

• **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

• **Identity theft victims and active duty military personnel have additional rights.** For more information, visit http://www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	PLEASE CONTACT:
Consumer reporting agencies, creditors and others not listed below	**Federal Trade Commission: Consumer Response Center – FCRA** Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	**Office of the Comptroller of the Currency** Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	**Federal Reserve Board** Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	**Office of Thrift Supervision** Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	**National Credit Union Administration** 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	**Federal Deposit Insurance Corporation** **Consumer Response Center** 2345 Grand Avenue, Suite 100 Kansas City, MO 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	**Department of Transportation, Office of Financial Management** Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	**Department of Agriculture** Office of Deputy Administrator- GIPSA Washington, DC 20250 202-720-7051

MANALAPAN SURGERY CENTER
50 FRANKLIN LANE, SUITE 101
MANALAPAN, NJ 07726
PHONE: (732) 617-5990 FAX: (732) 617-5999

ANESTHESIA PAT GUIDELINES

No P.A.T.'s required for MAC cases: e.g. Endoscopy, Pain Procedures, Major Nerve Blocks/Regional Anesthesia have the same clearance criteria as General Anesthesia.

Sedation Only Cases: BMI ≥ 45 or Sleep Apnea

General or Regional Anesthesia	EKG	LFT'S	PT/PTT	CBC	BUN/CRT	SMA-7	CXR
Healthy < 40 years old							
Healthy ≥ 40 years old	√						
HTN	√					√	
Diuretics	√					√	
Liver Disease, Warfarin		√	√				
Renal Insufficiency				√	√	√	
Diabetes	Age ≥ 40				√	√	
Hx CAD, Arrythmia, PPM	√			√			
COPD/Emphysema							√

- **All patients with pacemaker require Cardiac Clearance with documentation of pacemaker type and settings.**
- **Consents: Within 30 days of surgery date.**
- **EKG: 12 months prior to date of surgery, if no change in symptoms.**
- **CXES: 12 months prior to date of surgery.**
- **Lab work: Within 30 days of surgery date.**
- **H&P: Valid 30 days prior to scheduled procedure and update required day of procedure.**
  Podiatry cases require H&P from PCP for all patients.

PATIENTS PRECLUDED FROM SURGERY AT THE CENTER:

- **BMI ≥ 45: Requires airway screening prior to case confirmation.**
- **ASA IV (+) patients.**
- **Patients with AICD's (Internal Defibrillators) are ASA IV**
- **Patients with significant valvular disease. (e.g. Aortic Stenosis)**
- **Patients requiring home oxygen**
- **Patients with episodes on angina (chest pain) are ASA IV.**

Adult NPO Requirements: 8 hours for solids or clears

MEDICATION REQUIREMENTS:

- **Patients should take all regular medications (with small sip of water in the morning) EXCEPT:**
- **Stand-Alone diuretics (Lasix or HCTZ)**
- **Diabetics should not take their oral hypoglycemic medication the morning before surgery.**
- **Hold blood thinners at discretion of prescribing physician.**

CANCELLATION CRITERIA:

- **Any cardiac arrhythmia found that has not been previously documented.**
- **All diabetic patients require a finger blood sugar on admission BS ≥ 200.**
- **Any patient with SBP ≥ 200 or a DBP ≥ 100.**
- **Any patient found on admission to have a pulse oximetry ≤ 93% on room air or wheezing.**
- **Pregnancy tests required in all menstruation females unless h/o hysterectomy/menopausal for at least 1 year and tubal ligation.**

MANALAPAN SURGERY CENTER
50 FRANKLIN LANE, SUITE 101
MANALAPAN, NJ 07726
PHONE: (732) 617-5990 FAX: (732) 617-5999

January 5, 2015

To Whom it May Concern:

Please be advised that in order to book procedures at Manalapan Surgery Center, we need all booking forms and paperwork to be sent to us no later than 5 business days prior to the date of the scheduled procedure. If we do not receive all the required documents at least 5 business days in advance, we will not book the procedure in our center, and it will have to be rescheduled until we receive all of the information.

Also, please note that we have a new insurance form that needs to be completed along with the regular booking form for all procedures. The following is a list of all the required documents for booking for booking that must be sent to us, and they must be complete & legible:

- MSC Booking Form (completed, including correct CPT and DX codes)
- MSC Eligibility & Benefits Verification Form (Not Necessary for Medicare patients)
- Copy of Insurance Card (Front & Back)
- If pre-cert is required, please send:
  - Copy of APTP form.
  - Fax confirmation to insurance company.
  - Copy of Pre-cert Approval and/or Denial.
  - Copy of all Appeal letters, if denied, with fax confirmation and responses.
- If no pre-cert is required, please indicate on the booking form with reference number and name from the representative you spoke with.
- If it is an LOP case, please send copy of LOP addressed to Manalapan Surgery Center.
- History & Physical completed within 30 days prior to scheduled procedure.
- PAT paperwork, if required. (Please see attached PAT Guidelines).

We appreciate your help in ensuring that all bookings get done accurately and efficiently. If you have any questions, please contact us here at the center.

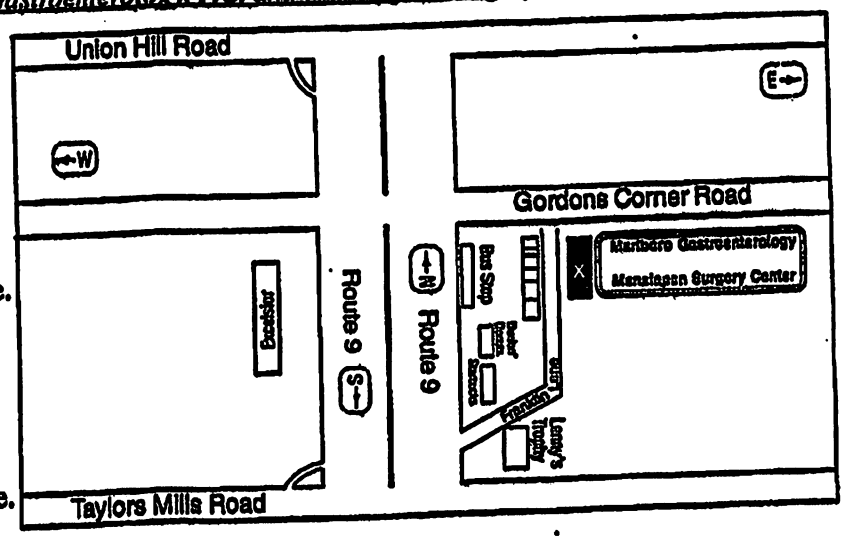
Sincerely,

MSC Staff

Directions to Marlboro Gastroenterology, P.C. and Manalapan Surgery Center

From North:
Take Route 9 South, 2½ Miles to
Taylors Mills Road.
Make Jughandle to Route 9 North.
Route 9 North for ¼ mile.
Franklin Lane is First street on right just
past Lenny's Trophy.
Office is on the right side less than ½ mile.

From South:
Take Route 9 North,
Pass Taylors Mills Road.
Turn Right at Lenny's Trophy
Office is on the right side less than ½ mile.



MANALAPAN SURGERY CENTER
ELIGIBILITY & BENEFITS VERIFICATION FORM

Patient Name (Last, First): _____, Date of Birth: _____

Insured Name (Last, First): _____, Date of Birth: _____

Insurance Company Name: _____ Phone # _____

COMMERCIAL INSURANCE

****** FACILITY IS NOT PAR WITH ANY COMMERCIAL CARRIER. IF NO OUT OF NETWORK BENEFITS PROCEDURE CANNOT BE DONE**********

Policy # _____ Group # _____ Effective Date: _____

Coverage: Yes / No Covered @ ____%, Procedure Being Authorized _____, Precert Needed: Yes / No

Authorization #: _____ Certifier Name: _____ Phone: _____ Fax: _____

Deductible: $_____, Amount met $_____ Out of Pocket: $_____, Amount met: $_____, Co- Insurance ____%

NO-FAULT/PIP

Policy # _____ Claim# _____ DOA: _____

State Policy Written: NY / NJ / OTHER _____

NEW YORK

Case Open: Yes / No, Benefits Exhausted: Yes / No, Amount Left on Policy: $_____, Pending IME/EUO: Yes / No

Type of IME: _____, Date IME/EUO Scheduled: _____

Adjuster Name _____ Ph: _____, Ext: _____

NEW JERSEY

Health Insurance Primary? Yes / No Copy of Policy Declaration Page on File: Yes / No Authorization on file : Yes / No

Authorization Expiry Date: _____

If not authorized, is proof of pre-cert with fax confirmation on file : Yes / No, Proof of Appeal: Yes / No

Certifier Name: _____ Phone: _____, Fax: _____

Adjuster Name _____ Ph: _____, Ext: _____ Fax: _____

Patient's Attorney Name: _____, Ph: _____ Fax: _____

WORKERS COMPENSATION

WCB # _____ CC# _____ DOA: _____

Case Still Open: Yes / No Established Body Parts: _____

Adjuster Name _____ Ph: _____, Ext: _____

Claim Submission Address: _____

_____

Representative Name: _____, Ref # _____, Information taken by: _____, Date: _____

Additional Notes: _____

Manalapan Surgery Center

50 Franklin Lane, Suite 101, Manalapan, NJ 07726 Tel: (732) 617-5990 Fax: (732) 862-1154

PATIENT BOOKING FORM

☐Medicare ☐Private/Commercial ☐NJ-PIP ☐NY-No Fault ☐WC ☐LOP ☐Self-Pay

Today's Date:	Diabetic? ☐YES ☐NO	Previous Admission: ☐YES ☐NO
Patient's First Name:	Last Name:	Social Security #:
Gender: ☐Male ☐Female		Date of Birth:
Height:	Weight:	BMI:
Patient's Home Address:		
City:	State:	Zip Code:
Home #:	Cell #:	Work#
Notify in Case of Emergency:	Phone#	Relationship:

Primary Insurance:	Claims Address:	
Insurance Co. Phone#:	Adjuster Contact Info:	
Policy ID#:	Claim#:	DOA/DOL:
Secondary Insurance:	Claims Address:	
Insurance Co. Phone#:	Adjuster Contact Info:	
Policy ID#:	Claim#:	DOA/DOL:
Attorney's Name:	Attorney's Phone:	Attorney's Fax:

PRIVATE INSURANCE/WC/PIP CASES MUST HAVE PRIOR AUTHORIZATION FOR APPROVED TREATMENT

Date of Procedure:	Time of Procedure:	Dr.
Procedure:		Diagnosis:
CPT Codes:		ICD 10 Code:
Anesthesia Type:	Referring Physician:	Phone#
Surgeon Requires Assistant: ☐YES ☐NO	Assistant Name:	Assistant Phone#:
Specific Supplies and/or Equipment:		
Patient Requires Rehabilitation? (i.e. CAREONE): ☐YES ☐NO		
Patient Needs Transportation: ☐YES ☐NO		
Pick-up Address (If different from Above):		
Schedulers Contact info:		
Name:	Phone#	Fax#

MUST FAX BACK WITH LEGIBLE COPY OF PATIENT'S INSURANCE CARD: FRONT & BACK*

Revised 8/1/16