Welcome To Lakewood Surgery Center

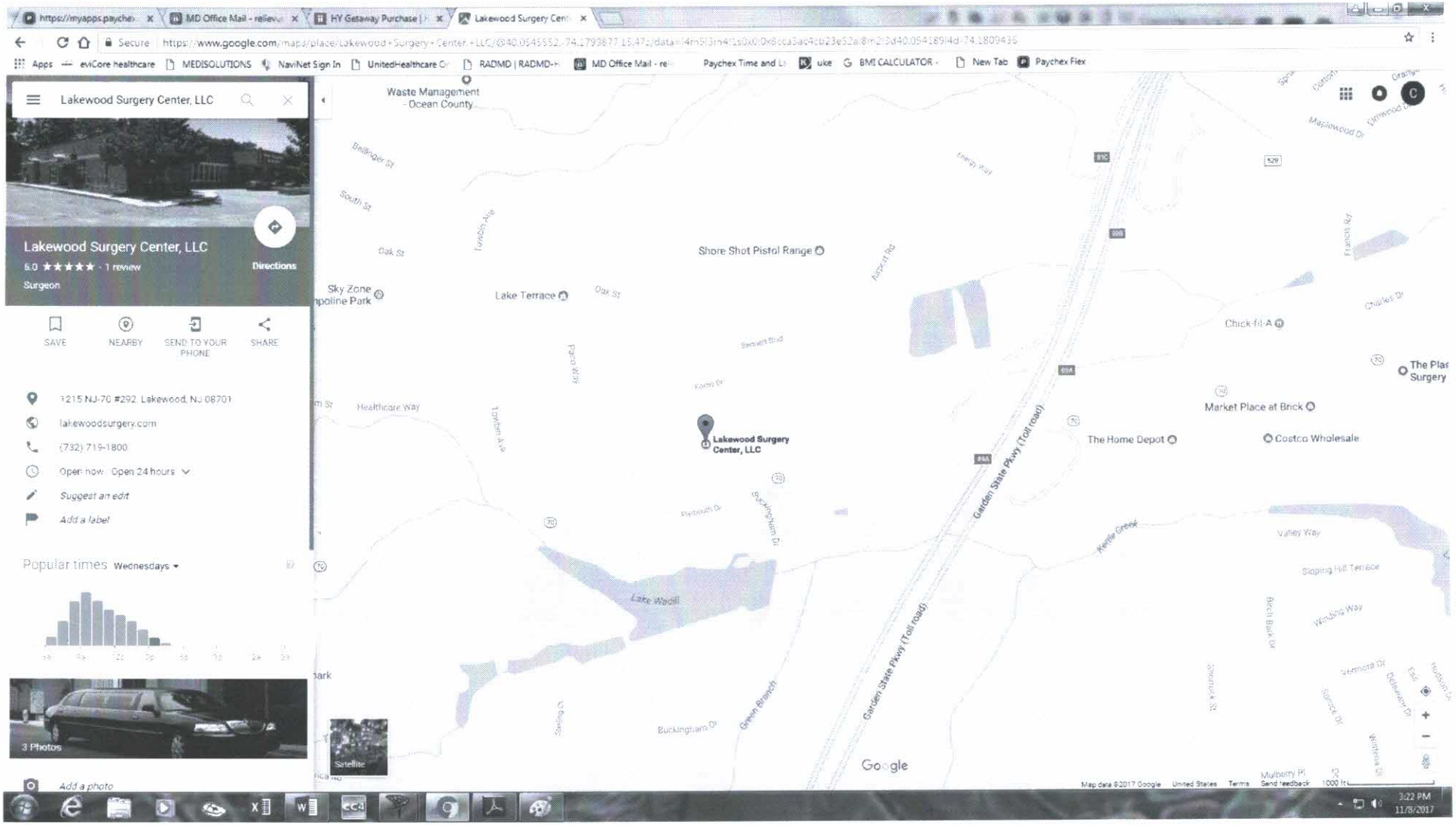
If you are one of our patients, I want to provide you a special welcome along with my personal commitment to provide you and your physician with excellence in both the clinical care and experience you have at our facility. Your health care team is comprised of highly trained, caring professionals who share my commitment.

Our center performs a broad range of outpatient surgical procedures. Our mission is to care for every patient and their family as if they were our own. Each patient, each family, each and every time.

This website is designed to familiarize you with our facility, answer any potential questions, and provide you with necessary information concerning what to expect before and after your procedure.

If you are a potential employee, we ask you to explore the entire website. If, after your review, you embrace our mission and philosophy we hope you will apply for employment, using this website.
Sincerely,

Rochele Herzog
Administrator


Lakewood Surgery Center, LLC
Lakewood Surgery Center, LLC
5.0 ★★★★★ · 1 review
Surgeon
Directions
SAVE
NEARBY
SEND TO YOUR PHONE
SHARE
1215 NJ-70 #292, Lakewood, NJ 08701
lakewoodsurgery.com
(732) 719-1800
Open now: Open 24 hours
Suggest an edit
Add a label
Popular times
Wednesdays
3 Photos
Add a photo
Satellite
Waste Management - Ocean County
Shore Shot Pistol Range
Sky Zone Trampoline Park
Lake Terrace
Chick-fil-A
Market Place at Brick
The Home Depot
Costco Wholesale
Lakewood Surgery Center, LLC
Garden State Pkwy (Toll road)
Lake Wadell
Google

Patient Label

Lakewood Surgery Center, LLC

1215 Route 70 Suite 2000
Lakewood, NJ 08701
(732) 719-1800

AUTHORIZATION FOR SURGICAL OR OTHER SPECIAL PROCEDURES

Patient's Name _____

1) I herby authorize and direct Dr. _____and associates or assistants of his/her choice to perform the following operation and any other procedure as he/she may deem necessary or advisable, on me, my child or ward:

_____

_____

_____

2) The basic procedures of my surgery and the advantages and the disadvantages, risks and possible complications of alternative treatments have been explained to me by the doctor. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction. As with ALL types of surgery, there is the possibility of other complications due to anesthesia, drugs, reactions or other factors which may involve other parts of my body, including a possibility of brain damage or even death. I am aware that there is a possibility of a hospital transfer in an emergency situation. Since it is impossible to state every complication that may occur as a result of surgery, the list of complications is incomplete.

3) I herby authorize and direct the above named surgeon to arrange for such additional services for me, as he/she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology and I hereby consent thereto.

4) I further consent to disposal by surgery center/hospital authorities, in accordance with its accustomed practice, of any tissue or parts, which may be removed.

5) I authorize the administration of transfusion of blood products to the above patient as may be deemed advisable in the judgment of the anesthesiologists, patients attending physician, and/or his/her associates or assistants. I understand that blood transfusions are not always successful in producing a desired result. I understand that despite the exercise of due care the transfusion of blood or blood products is always attended with a possibility of some ill effects such as the transmission of hepatitis, AIDS, or certain other diseases, accidental immunization, or allergic reactions. I understand that emergencies do on occasion arise when it may be necessary for the patient's well being to use existing stocks of blood which may not include the most compatible blood types.

6) I/We hereby authorize all doctors, pharmacies, Lakewood Surgery Center, LLC or other institutions rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered. (Including copies of their records.) I also authorize release of medical data that includes redisclosure of medical information obtained from other providers/hospitals.

7) I acknowledge that I have been advised by Lakewood Surgery Center, LLC personnel that I should not drive until the effects of any medications that I receive have worn off. This means I understand that I should not drive until the day after my operation, at the earliest.

8) I am aware that manufacturer's representatives and other observers may be admitted to the operating or treatment room if approved by the physician.

9) I understand that it is my responsibility to arrange for a responsible adult to drive me home and to be with me for twenty-four (24) hours following surgery.

10) I hereby consent to the use of video-taping or photography of my surgery at my surgeon's discretion and release the Lakewood Surgery Center, LLC from all liability from claims of any kind for the taking and use of these photographs or tapes.

11) I am aware that my physician may have ownership interest in Lakewood Surgery Center, LLC. If I choose to go to another health care facility for this procedure, it will have no effect on my relationship with my physician.

12) In the event of an accidental exposure to my blood and/or bodily fluids by a healthcare provider, I consent to testing for an infectious disease including HIV.

13) I release Lakewood Surgery Center, LLC from ANY responsibility for loss and/or damage to money, jewelry or other valuables brought into the Lakewood Surgery Center, LLC.

I AM STATING THAT I HAVE READ THIS CONSENT (OR IT HAS BEEN READ TO ME), AND I FULLY UNDERSTAND IT AND THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM THE SURGERY. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS.

Patient's Signature_____ **Date** _____

Witness to Signature _____ **Date** _____

INFORMED CONSENT

I have explained to _____ **(Patient, Guardian, or Proxy), the nature of the procedure, in layman's language, the necessity for the procedure its risks and benefits of those alternatives.**

Surgeon's Signature _____ **Date** _____

Lakewood Surgical center

- Address-1215 NJ-70 #292, Lakewood, NJ 08701
- Phone-(732) 719-1800

Every Wednesday start time 7:30 am

Anesthesia MAC sometimes LOCAL depending on patient

- DO NOT ACCEPT UNTITED HEALTH CARE PATIENTS
- Any patient over 50 needs an EKG 6 months prior to procedure

Do accept ARB and LOP patients

Surgical center calls patients with start time the day before procedure

- Patients must fill out onemedicalpassport.com before procedure date

Relievus™
Toll Free: (888) 985 - 2727 · Fax: (609) 567 - 8832

Patient No Show Agreement / Penalty

Welcome to Relievus. We are glad you have made an appointment for yourself or a family member.

Effective October 1, 2017 we will enforce a new Cancellation and No-Show Policy for Procedures. In order to provide you with high quality health care it is important for you to keep your scheduled appointment with the medical provider. Valuable time has been reserved for you or your family member. A missed appointment or late cancellation of an appointment results in lost time which could have been given to another person waiting to receive care. *Every day we get may calls for appointments. By cancelling your appointment as soon as possible, we can help other patients who are waiting to be seen.*

Our office will try to call 1-2 days ahead and remind you of your appointment; however, it is your responsibility to keep record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment please call 24 hours in advance between the hours of 8:00A and 5:00P. Patients who cancel appointments with less than **24 hours' notice will be considered a No Show.** Every No-Show visit will be recorded in your chart. Multiple No-Show appointments within a ***six-month period*** can end your ability to make appointments for procedures/treatments, EMG and EEG testing.

We realize that an emergency may occur, and you may not be able to notify us. We will discuss that situation with you when it happens.

No-Show Fee: You will be charged a fee of $100.00 for each no-show. You will still be able to receive medical services with our providers.

After Three (3) No-Shows: Your scheduling privileges will be suspended for *six months* and you will be treated for conservative care only, depending on provider availability. We cannot guarantee that you will be seen.

Thank you for working with us to ensure that services are provided to all our patients in the best possible way.

Acknowledgement of No-Show Agreement / Penalty

Signature: _____ **Date:** _____

Print Name: _____ **Date of Birth:** _____

If <u>Patient is a Minor</u> Print Name: _____ **Date of Birth:** _____

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Informed Consent for Pain Procedures

You have a pain problem that has not been relieved by routine treatments. A procedure, specifically an injection or operation, is now indicated for further evaluation or treatment of your pain. There is **NO guarantee** that a procedure will cure your pain, and in rare cases, **it could become WORSE**, even when the procedure is performed in a technically perfect manner. The degree and duration of pain relief varies from person to person, so after your procedure, we will reevaluate your progress, then determine if further treatment is necessary. Your physician will explain the details of the procedure listed below. Tell the physicians if you are taking any blood thinners such as **Plavix, Aspirin, Coumadin, Lovenox, or Heparin,** as these can cause excessive bleeding and a procedure should **NOT** be performed. Alternatives to the procedure include medications, physical therapy, acupuncture, surgery, etc. Benefits include increase likelihood of correct diagnosis and/or of decrease or elimination of pain.

Risks are

- **Increased pain and allergic reaction** from local anesthetics, iodine, contrast (X-Ray dye), materials containing latex, IV anesthetics and/or other medications.
- **Allergic reaction from steroid;** facial flushing, elevation in blood glucose, headache, increased appetite, weight gain, swelling, menstrual irregularities, hoarseness, numbness, infection, abnormal heartbeats, increased blood pressure, stroke, heart attack, insomnia, etc.
- **Infection** on skin, tissue, bones, joints, discs, nerves, ligaments, possibly blood stream (Sepsis), brain and spinal cord (Meningitis) may require hospitalization.
- **Bleeding** into epidural space (Epidural Hematoma) and into spinal canal (Spinal Hematoma) may require surgical interventions such as an evacuation of blood from epidural space or spinal canal and decompression surgery.
- **Nerve damage, nerve injury, tissue injury, tissue damage, temporary and permanent numbness and/or weakness, paralysis, spinal cord injury, urinary and/or fecal incontinence.**
- **Headache** ("Spinal headache") may require blood patch (injecting your own blood into epidural space) and hospitalization.
- **Death**
- **Stellate Ganglion Block:** In addition to the above complications, hoarseness, difficulty swallowing, seizure, air in lung requiring a chest tube in the hospital.

- **Trigger Point Injection, Peripheral Nerve block, Occipital Nerve Block:** In addition to the above complications, **air in lung (Pneumothorax)** requiring chest tube in hospital, local pain from tissue and/or nerve irritation, dimpling of depression in skin.
- **Joint Injection:** In addition to the above complications, **injection and fluid collection in the joint(s)** may require antibiotic treatment, fluid aspiration and surgical interventions.

Procedure: _____

The incidence of serious complications listed above requiring treatment is low, but it mat still occur. Your physician believes the benefits of the procedure outweigh its risks or it would not have been offered to you, and it is your decision and right to accept or decline to have the procedure done. **I have read or had read to me** the above information including the Pre-Procedure Patient Instruction page. I **UNDERSTAND** there are risks involved with spinal procedure, to include rare complications, which may not have been specifically mentioned above.

The risks have been explained to my satisfaction and I accept them and consent to any procedure which is performed by **a Relievus Medical Provider and its' associates including Physician Assistants and Nurse Practitioners in Relievus, LLC.** I herein authorize physicians, nurse practitioners and their associates in Relievus, LLC to perform this procedure. I also understand that one of the greatest risks involved with pain management procedures involves various medications taken, allergies and my general medical condition. I will inform the doctor of any blood thinning medication taken or any changes in other medications, allergies or medical condition prior to any procedure.

Patient/Legal Guardian Print Name	Patient Signature	Date
Witness Print Name	Witness Signature	Date

Medical Provider Declaration: I and/or my associate have explained the procedure and the pertinent contents of this document to the patient and have answered all the patient's questions. To the best of my knowledge, the patient has been adequately informed and the patient has considered to the above described procedure.

Medical Provider's Name	Medical Provider's Signature	Date

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Pre-Procedure Patient Instructions for Pain Management

(Your procedure is done at an **Ambulatory Surgical Center or Hospital**)

- Come with an **empty stomach**.
- Do **NOT** eat or drink anything at least **8 hours prior** to your procedure. (No food, water, soda, coffee, tea, Gatorade).
- Do **NOT** chew gum or suck on any candy/mint.
- If you are taking "blood thinning" medications, we must have a letter from the prescribing physician giving permission for you to stop the medication for the appropriate time period. Do not stop your medication until you have discussed this with your prescribing doctor and have written permission.

Injectable Medications:

- Aggrastat (tirofiban) — Stop **8 hours prior** to procedure.
- Angiomax (bivalirudin) — Stop **14 days prior** to procedure.
- Arixtra (fondaparinux) — Stop **7 days prior** to procedure.
- Heparin — Stop **24 hours prior** to procedure.
- Integrilin (eptifibatide) — Stop **8 hours prior** to procedure.
- Iprivask (desirudin) — Stop **14 days prior** to procedure.
- Lovenox — Stop **24 hours prior** to procedure.
- Novastan (argatroban) — Stop **14 days prior** to procedure.
- Orgaran (danaparoid) — Stop **7 days prior** to procedure.
- Refludan (lepirudin) — Stop **14 days prior** to procedure.
- ReoPro (abciximan) — Stop **2 days prior** to procedure.

Medications Taken by Mouth:

- Aspirin or aspirin containing medications (such as Excedrin) — Stop **7 days prior** to procedure.
- Brilinta (tricagrelor) — Stop **5 days prior** to procedure.
- Coumadin (warfarin) — Stop **5 days prior** to procedure.
- Dicumerol/Dicumarol — Stop **5 days prior** to procedure.
- Effient (prasugrel) — Stop **7 days prior** to procedure.
- Eliquis (apixaban) — Stop **3 days prior** to procedure.
- Elmiron — Stop **5 days prior** to procedure.
- Exanta (elagatran/ximelagatran) — Stop **14 days prior** to procedure.
- NSAIDs (Ibuprofen, Naproxen, Aleve, Diclofenac, Motrin, Advil, Mobic, Deuxis, Zorvolex, Zipsar, Vivlodex, Meloxicam, Voltaren, Arthrotec, Relafen, Indocin, Celebrex or similar anti-inflammatory medications etc.) — Stop **3 – 5 days prior** to procedure.
- Persantine (dipyridmole) — Stop **7 days prior** to procedure.
- Plavix (clopidogrel) — Stop **7 days prior** to procedure.
- Pletal (cilostazol) — Stop **7 days prior** to procedure.
- Pradaxa (dabigatran) — Stop **2 days prior** to procedure.
- Xarelto (rivaroxaban) — Stop **2 days prior** to procedure.
- Ticlid (ticlopidine) — Stop **14 days prior** to procedure.
- Vitamin E — Stop **3 days prior** to procedure.
- Do **NOT** take NSAIDs (Ibuprofen, Naproxen, Aleve, Diclofenac, Motrin, Advil, Mobic, Deuxis, Zorvolex, Zipsar, Vivlodex, Meloxicam, Voltaren, Arthrotec, Relafen, Indocin, Celebrex or similar anti-inflammatory medications etc.) **3-5 days prior** to your procedure (Acetaminophen = Tylenol is acceptable).
- Do **NOT** take Vitamin E, Fish Oil, Garlic, Ginki, Ginseng **5 days prior** to the procedure.

- If you are not sure, please feel free to ask us or call your local pharmacist.
- **Please continue to take** your blood pressure pills, seizure medications, asthma medications, thyroid medication, pain medications as prescribed/scheduled with a sip of water.
- You should have an **ESCORT** to drive you home due to the nature of the procedure. **THIS IS MANDATORY!** THE DRIVER MUST MEET you in the car. Procedures will be cancelled if you do not have a driver.
- You might require pre-procedure blood work if your procedure is a Discography, Disc Decompression or Spinal Cord Stimulator insertion.
- If you are allergic to **Latex**, please tell the physician immediately.
- If you are allergic to **Shell-Fish, Iodine Contrast, IVP Dye or CT Scan Contrast**, please tell the physician immediately.
- Please arrive **30 minutes before** your appointment time. This allows us time to complete the necessary paperwork and nursing assessments prior to the procedure.
- Wear loose fitting clothing the day of your procedure.
- Do not apply powder or cream over the area where the procedure is to be performed.

For more information, visit our website www.relievus.com or call the office at (888) 985-2727.

Female Patients

- If you are pregnant or trying to get pregnant, you MUST inform us immediately.
- **Urine pregnancy test** will be done prior to the procedure.

Diabetic Patients

- If you are Diabetic, you need to let us know and we will schedule your procedure early in the morning.
- Take ½ of your long acting insulin the morning of your procedure only.
- DO NOT take any oral diabetic medications.
- Please, check your glucose (finger stick) at home on the procedural day.

The above instruction was given to me and/or my guardian(s) at least 72 hours prior to the procedure. I have read or had read to me the above information including the surgical consent. I have followed the above instruction.

Patient or Legal Guardian's Name: _____

Patient's Signature: _____

Date: _____

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Home Care Instruction After Pain Procedure

Insertion Site Care

- Ice packs, if needed for the first 24 hours. Warm moist heating pads after that.
- May alternate ICE & HEAT every 10 minutes after 24 hours.

Activity

- Take it easy today! REST for 24 hours. Then, increase activity as tolerated.
- If you have weakness or numbness anywhere caused by the pain block, limit activity until sensation returns to normal.
- You may take a shower the next day and remove the band-aids.
- Avoid tub baths, whirlpools and swimming pools for the next 2-3 days.
- **If you received sedation via IV or you took any oral sedative medication (Valium, Xanax, Ativan, or Klonopin), DO NOT drive any vehicle, DO NOT operate any equipment for the next 24 hours and DO NOT make any important decisions for the next 24 hours.**

Diet & Med

- Drink plenty of fluids and resume normal diet as tolerated.
- Resume your medications as instructed including pain medication.
- Resume “Blood Thinners” Plavix, Coumadin, ASA, etc. as scheduled.
- You may take extra Tylenol and/or Motrin (Ibuprofen) if pain at the injection site.

What to Expect After the Procedure

- You may experience increased pain for 24 hours to 5 days after the injections, or a stiff, full, tight feeling. This is normal. Use ice and heat as needed.
- You may have bruising at the injection site. If so, apply ice.

Notify Your Doctor if Any of the Following Occur at (888) 985-2727

- Any skin rashes, hives, shortness of breath, or wheezing.
- An increase in your level of pain unrelieved by regular means.
- Persistent nausea or vomiting.
- Persistent headache which worsens upon sitting or standing.
- Chills/Fever (temperature greater than 101° F.
- To help us check the results of your pain block, please note if and when your pain returns. Also, record the time you begin taking any pain medications.
- Any other questions/concerns call the doctor’s office at **(888) 985-2727.**

Follow Up

- You should have a follow up appointment within 2-3 weeks. Please call the office at **(888) 985-2727** for a follow up appointment.
- Please try to remember quality of pain relief (0% ~ 100% pain relief) and the duration (3 hours, 1 day, 14 days, etc.)

_____ _____

Patient/Legal Guardian Signature Date