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CLEAVER MEDICAL GROUP  
SURGERY CENTER

## **Procedure Packet Table of Contents**

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**I have read and agreed to the following documents. All my questions and concerns have been answered by my provider and medical staff.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **For surgeries scheduled at Cleaver Medical Group Surgery Center:**

Our billing department will be contacting you and will provide you with an **ESTIMATED** cost analysis for **PHYSICIAN & FACILITY** fees. Until your claim is processed, an exact patient financial liability is not known. Therefore, the cost analysis our office provides is only an **ESTIMATE**. Patients will be financially responsible for any deductible, co-insurance and/or co-pay amounts assessed by the insurance company regardless of the estimated cost provided prior to surgery.

Anesthesia, imaging, and pre-op labs are not included in estimates provided by our office and will be billed separately by the facility providing the service. **Any questions regarding bills for these services, should be directed to the facility providing the service.**

Depending on the global period for the surgical procedures performed, post-operative visits may NOT be included in surgical fees and the patient will be responsible for any deductible, co-insurance and/or co-pay amounts assessed by the insurance company.

### **NO SHOW/MISSED APPOINTMENT POLICY**

We, at Cleaver Medical Group, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 770-872-6179.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder email, call and/or text to you are made/attempted prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

#### **PLEASE REVIEW THE FOLLOWING POLICY:**

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinicians at Cleaver Medical Group and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4. If you arrive 15 minutes late for your scheduled appointment you will be considered a "No-Show"
5. If you "No-Show" a surgery/procedure, we will apply a **\$250.00 "No-Show"** fee to your account. These fees will have to be paid in full before we schedule you for any additional appointments.

# CLEAVER MEDICAL GROUP SURGERY CENTER INSTRUCTIONS

## PATIENT RIGHTS

The patient has the right to:

1. become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may have a family member or representative of his/her choice be involved in his/her care.
2. exercise these rights without regard to race, sex, cultural, educational, or religious background or the source of payment for care.
3. be treated with respect, consideration, and dignity in a safe environment free from all forms of abuse or harassment.
4. remain free from seclusion or restraints of any form that are not medically necessary.
5. coordinate his/her care with physicians and healthcare providers and be provided, to the degree known, complete information concerning their diagnosis, evaluation, prognosis and any proposed treatment or procedures as needed to give informed consent or to refuse treatment. This information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment, non-treatment and the risks involved.
6. full consideration of patient privacy concerning consultation, examination, treatment, and surgery.
7. confidential treatment of all communications, disclosures and records pertaining to patient care; patients will be given the opportunity to approve or refuse their release except when release is required by law. Patient will have access to information in the medical record within reasonable time frame (48 hours).
8. leave the facility even against medical advice.
9. be informed about procedures for expressing suggestions, complaints and grievances including those required by state and federal regulations.
10. be informed by physician or designee to the continuing healthcare requirements after discharge.
11. examine and receive an explanation of the bill regardless of source of payment.
12. have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
13. interpretive services if needed.
14. be informed regarding patient conduct and responsibilities, services available at the surgery center, provisions for after-hours and emergency care, fees for services, payment policies, right to refuse participation in experimental research, charity and indigent care policy, charges for services not covered by third-party payors, and credentials of health care professionals.

## PATIENT RESPONSIBILITIES

The patient has the responsibility to:

1. provide complete and accurate information concerning present complaints, past illnesses, hospitalizations, other health issues, all medications.
2. make it known whether the planned surgical procedure/treatment risks, benefits and alternative treatments have been explained and understood.
3. follow the treatment plan established by the physician, including instructions by nurses and other health care professionals, given by the physician.
4. keep appointments or notify the facility in advance if unable to do so.
5. accept full responsibility for deciding to refuse treatment and/or not follow directions.
6. fulfill the financial obligations of his/her care as promptly as possible.
7. be respectful of all the health care providers and staff, as well as other patients in the facility and follow facility policies and procedures.
8. notify the staff if they have any safety concerns or feel their privacy is being violated.
9. provide a responsible adult to transport him/her from the surgery center and remain with him/her for 24 hours, if required by his/her provider.
10. inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

## PATIENT COMPLAINTS

Patients have the right to register a complaint, in writing, to the Administrator of Cleaver Medical Group Surgery Center. Please submit complaint to:

ATTN: Ashley Dorsey  
Cleaver Medical Group Surgery Center  
105 Professional Park Drive Suite 200  
Cumming, GA 30040

If the complaint is not resolved to the patient's satisfaction, he/she has a right to file a grievance with the Healthcare Facility Regulation Division, Department of Community Health, Complaints Unit or Accreditation Association for Ambulatory Health Care (AAAHC) for concerns against the surgery center, the Georgia Composite Medical Board concerning the physician or the Professional Licensing Boards Division, Georgia Board of Nursing with concerns against any of the nursing staff. The patient should provide the physician or surgery center name, and address and the specific nature of the complaint.

### **COMPLAINTS AGAINST THE ASC:**

Healthcare Facility Regulation Division  
Department of Community Health  
Attn: Complaints Unit  
2 Peachtree Street, N.W., Suite 31-447  
Atlanta, Georgia 30303-3142  
  
P: (800) 878-6442  
F: (404) 657-8935  
  
ONLINE:  
<https://dch.georgia.gov/divisionsoffices/healthcare-facility-regulation/facility-licensure/hfr-file-complaint>

### **COMPLAINTS AGAINST THE PHYSICIAN:**

AAAHC  
5250 Old Orchard Road, Suite  
200  
Skokie, Illinois 60077  
  
P: (847) 853-6060  
F: (847) 853-9028  
  
E-mail: [info@AAAHC.org](mailto:info@AAAHC.org)  
  
ONLINE: <https://gcmb.mylicense.com/verification/Search.aspx?SubmitComplaint=Y>

### **COMPLAINTS AGAINST NURSING STAFF:**

Professional Licensing Boards Division  
Georgia Board of Nursing  
237 Coliseum Drive  
Macon, Georgia 31217-3858  
  
P: (844) 753-7825  
  
ONLINE:  
<http://verify.sos.ga.gov/verification/Search.aspx?SubmitComplaint=Y>  
  
ISSUES REGARDING MEDICARE:  
<http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>  
or call 1-800-MEDICARE

I verify I have received and understand the information regarding Patient Rights and Responsibilities, Patient Privacy and Grievance Procedures.

Patient/Guardian Signature

Relationship to Patient

Date/Time

# CLEAVER MEDICAL GROUP SURGERY CENTER

## NOTICE OF PRIVACY PRACTICES EFFECTIVE MAY 2021

### HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the facility may be billed to and payment may be collected from you, an insurance company or a third party.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are involved in taking care of you at the facility or the hospital.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations such as quality improvement efforts. These uses and disclosures are necessary to run the facility and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other facility personnel for review and education purposes.

**WHO WILL FOLLOW THIS NOTICE:** Any health care professional authorized to enter information into your medical chart including all facility doctors, nurses and personnel will abide by this notice.

**POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION.** We create a record of the care and services you receive at the facility. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel or by your doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include appointment reminders; as required by law; for public health-related benefits and services; to individuals involved in your care or payment for your care; research; and to avert a serious threat to health or safety. Other uses and disclosures of your personal information could include disclosure to, or for: medical examiners; law enforcement; lawsuits and disputes; military and veterans; national security; public health risks; and worker's compensation.

### NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" listing the disclosures we have made of medical information about you.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Administrator, and you must provide a reason that supports your request. We may deny your request for an amendment.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care.

**Right to a Paper Copy of this Notice.** You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way. You must make your request in writing, and you must specify how or where you wish to be contacted.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Administrator.

### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint. **You will not be penalized for filing a complaint.**

#### **COMPLAINTS AGAINST THE ASC:**

Healthcare Facility Regulation Division  
Department of Community Health  
Attn: Complaints Unit  
2 Peachtree Street, N.W., Suite 31-447  
Atlanta, Georgia 30303-3142

P: (800) 878-6442  
F: (404) 657-8935

ONLINE:  
<https://dch.georgia.gov/divisionsoffices/healthcare-facility-regulation/facility-licensure/hfr-file-complaint>

#### **COMPLAINTS AGAINST THE PHYSICIAN:**

AAAHC  
5250 Old Orchard Road, Suite 200  
Skokie, Illinois 60077  
P: (847) 853-6060  
F: (847) 853-9028  
E-mail: [info@AAAHC.org](mailto:info@AAAHC.org)

Georgia Composite Medical Board  
Enforcement Unit  
2 Peachtree Street, N.W., 6<sup>th</sup> Floor  
Atlanta, Georgia 30303  
P: (404) 656-3913, select option #3  
F: (404) 656-9723

ONLINE: <https://gcmb.mylicense.com/verification/Search.aspx?SubmitComplaint=Y>

#### **COMPLAINTS AGAINST NURSING STAFF:**

Professional Licensing Boards Division  
Georgia Board of Nursing  
237 Coliseum Drive  
Macon, Georgia 31217-3858

P: (844) 753-7825

ONLINE:  
<http://verify.sos.ga.gov/verification/Search.aspx?SubmitComplaint=Y>

#### **ISSUES REGARDING MEDICARE:**

<http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>  
or call 1-800-MEDICARE

**CHANGES TO THIS NOTICE.** We reserve the right to change this notice. A copy of the current notice will be posted in the waiting room.

If you have any questions about this notice or need further information, please contact: Ashley Dorsey, Administrator at (770)746.6380.

# CLEAVER MEDICAL GROUP SURGERY CENTER

## CONSENT AND TREATMENT AUTHORIZATION

I hereby consent to the rendering of such care and treatment as the physicians and medical staff of Cleaver Medical Group Surgery Center consider to be necessary and appropriate. The consent to receive medical treatment includes, but is not limited to, examinations, diagnostic and therapeutic procedures, medications, anesthesia, and any other medical treatment and services which I may require. I hereby acknowledge that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may involve risk of injury and of adverse results. I hereby acknowledge that no guarantees have been made to me as to the results of the procedures, which I may undergo while a patient of Cleaver Medical Group Surgery Center.

### ACKNOWLEDGEMENT OF PATIENT

I understand that:

- a) my physician or Cleaver Medical Group Surgery Center may permit one or more observers to be present during my surgery for educational, accreditation or licensing purposes. Photography of my surgery may occur at my physician's discretion.
- b) I should not drive until the effects of any medication received have worn off. I must have a responsible adult drive me home if I received sedation.
- c) the Cleaver Medical Group Surgery Center is not responsible for the loss of or damage to any article of value brought to the facility.
- d) because of the possible adverse effects of some medications on an unborn fetus, it is important to know if I am pregnant. Therefore, I certify that to the best of my knowledge, I am NOT pregnant.

### ADVANCE DIRECTIVES

Cleaver Medical Group Surgery Center will ask me if I have executed an advance directive. I am aware that Cleaver Medical Group Surgery Center typically treats healthy patients undergoing elective procedures. Therefore, the extent to which my Advance Directive specifies may be limited. I consent to resuscitative measures as deemed necessary by my physician in the event of a life-threatening emergency. I consent to emergency transfer to Northside Forsyth Hospital in case of the need for emergency hospital care. A copy of my Advance Directive, if provided, will be placed on my chart, and transferred to the hospital in the event of a transfer. Information regarding Advance Directive has been made available to me preoperatively. Northside Forsyth Hospital is not affiliated or in partnership with Cleaver Medical Group Surgery Center.

### OWNERSHIP

I understand that Cleaver Medical Group Surgery Center is owned by Miranda Reed, DO (100%). I have been given the option of having my surgery at a facility not owned by physicians and choose to have my surgery at Cleaver Medical Group Surgery Center.

### GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated, and reported to the Administrator of Cleaver Medical Group Surgery Center. Any substantiated allegation will be reported to the State and/or local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within (20) days of receipt of the grievance. The contact information for the State of Georgia is included on the Patient Bill of Rights that I received. The patient will be advised of the grievance status throughout the process.

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the request and/or release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary for processing insurance claims, utilization review, quality assurance activities or continuity of care. This authorization applies to all healthcare providers involved in my treatment at the facility.

### ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I hereby assign to Cleaver Medical Group Surgery Center all surgical, medical insurance and/or other benefits for services rendered by Cleaver Medical Group Surgery Center. It is the policy of Cleaver Medical Group Surgery Center to collect payment at the time of service. Cleaver Medical Group Surgery Center will file a claim to my insurance. I am aware that any charges NOT COVERED by my insurance policy, including co-insurance and deductible, are my responsibility. I understand that my insurance company may send payments for the rendered services to me. I agree to endorse the insurance check(s) over to Cleaver Medical Group Surgery Center. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud.

I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT.

Patient/Guardian Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Rev. 2021



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CLEAVER MEDICAL GROUP  
SURGERY CENTER

## COVID-19 Policy

### Patient Screening:

Every patient will be screened for COVID-19 symptoms upon arrival for their scheduled procedure. **It is MANDATORY that ALL patients have their temperature taken upon entry into the surgery center.** If anyone has a temperature of **100.4** or greater, they will be rescheduled.

Patients are also screened during appointment reminder calls. If the patient answers “yes” to any of the screening questions, they will need to be rescheduled.

### Mask Protocol:

**Vaccinated or not we require universal masking. Patients MUST wear a mask at all times while in the facility. If patients choose to not wear a mask, they will be rescheduled.**

### Cleaning/Disinfecting:

- Waiting rooms will be cleaned frequently.
- Our exam rooms and treatment rooms are to be cleaned and disinfected frequently, including before and after each patient.
- Hand sanitizer is available.
- Wash hands frequently.
- Doctors, nurses, and all medical staff members should sanitize or wash their hands before and after interacting with patients.

### Social Distancing & Visitors:

- We will not be allowing any visitors during this time.
- Drivers are allowed to come in upon arrival to obtain signature, they will then be asked to wait in the car while procedure is being performed.

### Risks:

*I understand that various aspects of the procedure, that may include going under anesthesia, performing an invasive procedure (surgery or injection), administration of steroids, and being near other people (medical staff, other patients) all may increase my risk. These risks include higher chance of exposure to the corona virus, developing COVID-19 infection, and getting sicker from the virus, than if I did not have the procedure performed. I understand that COVID-19 can cause severe illness and death.*

*My doctor and I have determined that at this time, this procedure is medically necessary for my health and well-being and is an elective procedure. We agree that if we wait until the pandemic has resolved, this will probably lead to worsening of my medical condition. I understand and accept these increased risks, and I understand that these risks are in addition to the standard risks associated with this procedure*



CLEAVER MEDICAL GROUP  
SURGERY CENTER

## Anticoagulant “Blood Thinner” Instructions

**Some medications need to be stopped prior to certain procedures. If you are taking a blood thinning medication, we must have clearance from the prescribing physician that it is ok for you to stop taking a blood thinning medication.**

**For your safety, do not stop taking these medications before approval is received from your prescribing physician.**

Blood Thinner Restrictions for Epidural and Cervical Procedures				
7 days	5 days	3 days	1 day	8 hours
	Coumadin/Jantoven (Warfarin)	Pletal (Cilostazol)	Lovenox (enoxaparin)	<i>SubQ heparin</i>
Plavix (Clopidogrel)	Arixtra (fondaparinux)	Eliquis (apixaban)	Fragmin (dalteparin)	
Effient (Prasugrel)	Pradaxa (dabigatran)	Xarelto (rivaroxaban)	Aggrastat (tirofiban)	
Trental (Pentoxifylline)	Brilinta (Ticagrelor)	Savaysa (edoxaban)	Integrelin (eptifibatide)	
	Aggrenox (Aspirin/Dipyrimidole)			
	Aspirin-Cervical Epidural Steroid Injections only			

Major Procedures (Procedures requiring an incision) and Trials <i>To include above instructions if applicable</i>	
7 days	Fish oil, Vitamin E, Ginkgo, NSAIDs, and/or Aspirin

If your blood thinner medication is not in the above table, please contact your doctor for further information regarding management.



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CLEAVER MEDICAL GROUP  
SURGERY CENTER

## **Diabetic Pre-op Instructions**

- It is crucial that your blood glucose level is optimized prior to the procedure.
- We will make every effort to schedule diabetic patients early in the morning
- Steroid injections may **elevate your blood sugar** after your procedure. After the injection, **check your blood sugar** frequently for next **2-3 days** and make adjustments as necessary. You may have to notify your doctor who treats your diabetes so the blood sugar can be treated appropriately.
- Your blood glucose will be measured when you arrive on your procedure day. **Your fasting blood glucose level should be less than 180 mg/dL. If your blood glucose is more than 200 mg/dL your procedure may need to be rescheduled.** Your doctor will make the final determination.
- Oral diabetic medications (e.g., metformin) should not be taken on the morning of your procedure until normal diet is resumed
- If you are on intermediate insulin, you should take 50% of your morning dose
- If you have any questions regarding your diabetic medications, please speak to your prescribing doctor



## Injection Pre-Procedure Instructions

You are scheduled for a \_\_\_\_\_ Injection at Cleaver Medical Group ASC on \_\_\_\_\_  
(Date) at \_\_\_\_\_ (Time)

- Please arrive 30 minutes before your scheduled procedure time. Bring your photo ID, insurance card(s), and required payment (co-pay, co-insurance, deductible).
- Please have a responsible driver over the age of 18, who can stay in the surgery center waiting area for the duration of your procedure. Uber/ taxi driver may be used for transportation, but you must have a responsible adult who will be with you throughout the procedure and to accompany you home afterwards.
- If you take a prescription blood thinner/anticoagulants, please stop **BEFORE** your procedure in the following time frames:
  - Plavix (Clopidogrel) - Patient will need to stop 7 days before the procedure.
  - Coumadin (Warfarin) - Patient will need to stop 5 days before the procedure.
  - Xarelto (Rivaroxaban) - Patient will need to stop 3 days before the procedure.
  - Eliquis (Apixaban) - Patient will need to stop 5 days before the procedure.
  - Pletal (Cilostazol) - Patient will need to stop 3 days before the procedure.
  - Pradaxa (Dabigatran Etexilate) -Patient will need to stop 5 days before the procedure.
  - Brillinta (Ticagrelor) - Patient will need to stop 5 days before the procedure.
  - Arixtra (Fondaparinux) - Patient will need to stop 4 days before the procedure.
  - Dipyridamole (Persantine) - Patient will need to stop 2 days before the procedure.
  - Aspirin - Patient will need to stop 7-10 days before the procedure.
- If you have been started on an antibiotic by another physician for an active infection, please notify our office 24 hours before your scheduled procedure.
- IF YOUR SURGERY REQUIRES SEDATION THE FOLLOWING INSTRUCTIONS APPLY:
  - **DO NOT** eat or drink anything after midnight the night before the procedure.
  - **YOU MAY TAKE** medication early in the morning the day of the procedure with a sip of water
  - **YOU MAY HAVE** clear liquids ONLY (Sprite, Apple Juice, Water, Gatorade, etc.) after midnight the night before the procedure and up until 2 hours prior to the arrival time of the procedure.
  - You should have **NO CLEAR LIQUIDS** to drink for 2 hours prior to the arrival time.
- DAY OF PROCEDURE:
  - Take your medication with a clear liquid the morning of the procedure if directed to do so by the nurse.
  - Arrange to have an adult drive you home **AFTER** the procedure.
  - Take a bath or shower
  - Wear loose fitting, comfortable clothing. No metal anywhere on your body or clothing.
  - **DO NOT** bring any jewelry or valuables with you to the surgery center.
  - **DO NOT** bring small children to the surgery center the day of the procedure.
  - Due to limited seating in the waiting area, please limit guests to 1 per patient.
  - Please plan to arrive 30 minutes prior to the appointment scheduled.
  - Please bring ID, insurance information, list of medications, and required payment the day of the procedure.

PLEASE NOTE:

1. Failure to follow instructions or late arrival for your appointment may result in cancellation/ delay of the procedure.
2. If you have any questions or are unable to get to Cleaver Medical Group Surgery Center the day of the scheduled procedure, please call 770-872-6179 within 24 hours of the appointment date. Failure to do so may result in a "no show fee".

I authorize CMG ASC to leave messages regarding my procedure at this phone number: \_\_\_\_\_

**Failure to adhere to these guidelines will result in us not being able to perform your procedure.**

Patient Name (Printed): \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Sprint Peripheral Nerve Stimulator Procedure**

The SPRINT PNS System is a short-term treatment offering long-term relief from chronic pain:

- Short-term, 60-day treatment
- No permanent implant, No incision, No surgical procedure
- Minimally invasive and drug-free

The SPRINT PNS System consists of a lead constructed of a very fine wire, approximately the same size as a human hair, a small pulse generator connected to a mounting pad that sticks to the outside of the patient's body, and a simple user-friendly handheld remote.

### **How does Peripheral Nerve Stimulation work?**

Our breakthrough treatment is proven to provide significant and sustained relief from chronic pain and works by selectively stimulating targeted peripheral nerve fibers. The SPRINT System sends mild electrical pulses directly to the nerves, which can reduce pain signals. This in turn rebalances and restores healthy cortical processing with focal and robust non-painful signals.

### **How is the PNS system temporarily implanted?**

The physician confirms the specific region of pain. Using ultrasound guidance and/or fluoroscopy, the physician locates the target nerve(s) for lead placement. Under local anesthetic the physician places the lead near the target nerve(s) (approximately 1-3cm away from the nerve) and verbal assistance from the patient confirms the correct area of coverage. Once placement is confirmed, the lead is connected to the external pulse generator that sticks onto the patient's body. The patient is given detailed care instructions, sent home, and treatment is delivered for up to 60 days. The PNS representative will continuously follow up with the patient during the entire duration of treatment.

#### **One Week Before Procedure:**

- Notify Cleaver Surgery Center if you are started on an antibiotic prior to your procedure. If you are being treated for an active infection, the procedure will have to be re-scheduled to prevent complications.

#### **The Day of the Procedure:**

- Please take any scheduled medications including blood pressure medications with a small sip of water
- Please try to wear comfortable clothing that is stretchy or can be maneuvered to expose the area for the procedure.

#### **Pre-op area:**

- Please use the restroom on arrival to pre-op area if needed.
- Vital signs will be checked. If your blood pressure or blood glucose exceeds our cut off levels, your procedure will be re-scheduled.
- Consents will be signed and witnessed by staff.
- Discharge instructions will be provided.

# DISCHARGE INSTRUCTIONS FOLLOWING PLACEMENT OF **SPRINT®** PERIPHERAL NERVE STIMULATION SYSTEM

If your question is not answered here, please ask your nurse or doctor for more information.

## ACTIVITY

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- Limit strenuous physical activity & motion (such as twisting, bending, climbing, lifting) near the implant for at least one week. Avoid excessive stress (tugging, pressure, heat) that may damage the stimulation system.
- You may resume exercise and/or physical therapy when directed by your doctor.
- Do not use the system while driving, operating machinery, or during any activity in which sudden muscle tension may put you at risk of injury.
- Never soak the exit site in water. It is okay to shower. Always remove the Pulse Generator (stimulator) and Mounting Pad from your body and keep the Waterproof Bandage over your exit site when showering.
- Review the *Warnings, Precautions & Risks* section in the *Patient Instructions for Use* for potential hazards that may cause injury, discomfort, or damage to your system. Examples include MRI & diathermy.

## SYSTEM USE AT HOME

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- Make sure that the Pulse Generator is snapped onto a Mounting Pad. The entire surface of the Mounting Pad must be in contact with your skin. Check that all cables are firmly connected.
- Turn stimulation ON  for the following amount each day (check one):  6-12 hours  24 hours
- If stimulation feels uncomfortable or painful, decrease the intensity to a level that is comfortable.
- Replace & recharge the Pulse Generator battery when the battery icon on your remote shows 1 bar 
- Always have one battery charging in the Recharging Base so that you never miss your daily therapy.

## CLEANING & CARE

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- A MicroLead (thin, thread-like wire) exits your skin under the Waterproof Bandage. Do not pull on it.
- Change the Waterproof Bandage & Cradle when they become soiled, damp, or no longer adhere well to the skin (about every 4-5 days). Take care when removing these to prevent pulling the MicroLead out.
- Clean skin under the bandage with mild soap & water OR wipe skin with an alcohol pad. Allow skin to dry.
- When placing a new bandage, make sure that no part of the adhesive touches the MicroLead or Connector.
- Review the *Changing the Bandage and Cradle* section of the *QUICK START GUIDE* for detailed instructions.
- Check the skin under the bandage for redness, swelling, drainage, or bleeding during bandage changes.
- If any of these signs are present, or if your MicroLead(s) pull out, notify your doctor and an SPR Therapeutics representative:

## TROUBLESHOOTING

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- Review the *QUICK START GUIDE* and the *Appendix B: Troubleshooting* section in the *Patient Instructions for Use* for assistance with your device.
- Additional instructional videos and patient resources are available at the SPR Therapeutics website: <https://www.sprtherapeutics.com/quickstart>
- If you are running low on any supplies, or if you need help with other questions, problems, or errors on your remote, please call an SPR Therapeutics representative:

# DISCHARGE INSTRUCTIONS FOLLOWING PLACEMENT OF **SPRINT**® PERIPHERAL NERVE STIMULATION SYSTEM

## ADDITIONAL INSTRUCTIONS

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

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DATE