Randall E. Niederkohr

Board Certified Pediatric Dentist

655 Fox Run Road ✦ Suite E ✦ Findlay, Ohio 45840
Office: 419-595-4921
e-mail: pedorandall109@gmail.com

Outpatient Surgery Information

Your child, _____ is scheduled for outpatient surgery at _____ on _____.

Depending on which hospital your child's care will be completed (Tiffin Mercy or Wyandot Memorial, Upper Sandusky) someone will be contacting you regarding the date of surgery as well as the time to arrive at the hospital, any history and physical issues, and special instructions for your child for the day of surgery.

Your insurance provider will be contacted to obtain authorization for the treatment with Dr. Niederkohr and the hospital to which the treatment will be rendered. If the authorization is not obtained and you would like to proceed with treatment, you will be responsible for the financial cost of the completed treatment.

- If at any time your contact phone number or address has changed or been disconnected it is your responsibility to contact Dr. Niederkohr's office at (419)-595-4921 and give your updated contact information. If no contact number is available your child's treatment will be cancelled and it becomes your responsibility to get the case rescheduled. This could cause a much later treatment date or not even available if insurance authorization is not to be obtained.
- All operating room cases are treated with the youngest child going first, unless a medical condition requires the case to be done out of the normal age order.
- If your child is sick then you need to contact the hospital to cancel the case. Wyandot Memorial is at (419) 294-4991 or Tiffin Mercy is at (419) 455-7000. Ask for outpatient surgery.
- Nothing to eat or drink outside the hospital guidelines given by the hospital where treatment Will be completed or surgery will be canceled. NO EXCEPTIONS.

Please remember that the above guidelines are for your child's safety and wellbeing.

Please follow them completely.

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Outpatient Surgery Information

(Continued)

A required history and physical (H&P) needs to be faxed to Wyandot Memorial (419) 294-4991 or Tiffin Mercy (419) 455-7000. Please bring the completed H&P forms to the hospital with you on the day of your child's surgery.

If we do not have a copy of this completed form at the hospital, your child's case will be cancelled and rescheduled.

Initials _____ Date: _____

I understand the guidelines listed and have been made aware of the required health and physical guidelines as determined by the specific hospital which treatment will be rendered. I understand that if these guidelines are not followed my child's case may be cancelled / rescheduled.

Parent Name (Print): _____

Parent Signature: _____X_____

Date: _____

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Financial Responsibility Notification

Provider may bill the member when insurance has denied prior authorization or denied a referral, or the service is not covered if following conditions are met:

1. The patient must be notified that the service to be rendered is their personal financial liability in **advance** of service delivery.
2. The notification by Dr. Niederkohr was in writing, specific to the service being rendered, and clearly states that the patient is financially responsible for the specific service. A general liability statement signed by all patients or for all services is not sufficient for this purpose.

Provider Section

Specific Service to be rendered: _____

_____

Scheduled Date of Service: _____

Amount patient / parent will be responsible for _____

Guarantor Section

I understand that the service to be listed above will not be approved by my insurance or is not a covered service through ODJKS. I clearly understand that I will be billed by Dr. Niederkohr for this service and that I am financially liable. Dr. Niederkohr may not submit a bill to insurance.

Patient Name _____

Parent Signature _____ Date _____

fax 419-455-7604
419-447-7063

1HPO

History & Physical Procedures

Name of Patient_____ DOB_____ Date_____

History of Present Illness _____

_____

_____

Past Medical History: ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Renal Disease

_____

Current Medications: ☐ Medication reconciliation list reviewed _____

General: ☐ Alert & Oriented _____ Ht:_____ Wt:_____

Skin: _____

Heart: ☐ Regular Rate & Rhythm _____

Lungs: ☐ Clear _____

Abdomen: _____

Impression: _____

Plan: _____

_____

Physician Signature Date/Time

☐ Patient examined H&P reviewed
No change in condition

_____
Physician signature Time Date

Progress Notes Post Procedure

Date of Surgery_____

Pre-procedure diagnosis: _____

Post-procedure diagnosis:_____

Procedure: _____

Anesthesia Provider:_____

Type of Anesthesia: Sedation MAC Local Other

Estimated Blood Loss _____ml None

Findings: _____

Specimen(s): None Disposition: Pathology Discarded Other

Patient's Condition on Discharge Stable Unstable

Physician Signature_____ Time_____ Date_____

FORM #41 rev 5/18

Mercy Health Tiffin