Implant Pre-Op Instructions

InterStim® Therapy for Bladder and Bowel Control

Appointment & Transportation Manager:

(870) 416-0904

Implant Date: _____

Arrival Time: _____

Notes: _____

_____

_____

_____

Dr. Chris Taylor
www.drchristaylor.com

1425 Rock Springs Road
Harrison, AR 72601

Phone: (870) 741-1616
Fax: (870) 741-2211

Congratulations on taking the first step towards restoring control and reclaiming your life!

The most important thing we want you to know today is that **you are not alone**. We're here to help you live life to the fullest again—doing things you enjoy like taking your grandkids to the park, eating out with friends, sitting through a movie, or just getting a good night's sleep again!

This instruction packet provides important information regarding the InterStim® Therapy for Bladder and Bowel Control implant procedure. It includes detailed instructions outlining what to do between now and the day of the procedure, what we'll do on the day of the procedure, and what to do after the procedure.

This packet also includes examples of the surgical consents you will be asked to sign on the day of the implant procedure. Please review them in advance and don't hesitate to call if you have any questions.

Congratulations again on choosing to reclaim control of your life! You no longer have to be a prisoner to fear, anxiety, or embarrassment. You no longer have to live with life-controlling symptoms. And best of all, your world won't revolve around the bathroom anymore!

Sincerely,

Chris Taylor

Dr. Chris Taylor and Staff

Dr. Chris Taylor
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Before Arriving

General Instructions

- Nothing to eat or drink, including gum or hard candy, for at least 6 hours prior to procedure.
- Please shower and wash buttocks area with antibacterial soap the night before the procedure.
- Wear loose, comfortable clothing.
- Leave jewelry and other valuables at home.
- You may wear your glasses. Please bring your case. No contact lenses.
- If you wear dentures or partials, please bring a container for them.

Medication Instructions

- Blood Thinners: Blood thinners must be stopped prior to the implant. Specifics will be determined by Dr. Taylor in accordance with the recommendations of your prescribing physician.
- Non-Steroidal Anti-Inflammatory Drugs (NSAIDS): **DO NOT** take aspirin, ibuprofen (Advil®, Motrin®, etc.), naproxen (Aleve®), or any other NSAID for 3 – 5 days prior to the procedure unless otherwise instructed by Dr. Taylor.
- Blood Pressure Medication: You may take blood pressure medications the morning of the procedure with a **SMALL** sip of water. Bring your other morning medications with you.

Diabetic Patients

- **DO NOT** take your morning insulin or diabetic medications.
- Bring your diabetic medications with you.
- We have refreshments, but you may bring your favorite snack to eat in recovery if desired.

Anesthesia

- If you are **NOT** using our transportation services, **YOU MUST HAVE A DRIVER**.
- If you are using our transportation services, you may come alone or you may bring one family member or friend to ride with you.
- You must have someone with you or responsible for you for 12 hours after receiving IV sedation.

Day of Procedure

Before Procedure

- Please plan to arrive at your scheduled time.
- Your family member or friend may accompany you into the pre-op area.
- Vital signs will be taken, and you will sign your consents.

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- Our staff will review post-op instructions and schedule your 2-week post-op appointment*.
  **Long distance patients may opt for a phone visit with a nurse if not experiencing any problems.*
- The anesthesia provider will review your health history and answer any questions.
- The Medtronic InterStim® technician will provide instructions regarding the device.
- Dr. Taylor will speak with you and your family member or friend to answer any questions.
- Your family member or friend will be asked to go to the waiting room and be given 2 prescriptions to fill for you while you are in the procedure.
- You will change into a patient gown, an IV will be started, and sequential compression devices (SCD's) will be placed on your lower legs to assist with circulation.

In the Surgical Suite

- The procedure will take approximately 30 minutes and will take place in the same room we did the InterStim® test.
- We will assist you onto the table and you will be positioned on your abdomen, the same as you were positioned during the test, and given oxygen to breathe.
- The anesthesia provider will administer IV sedation and monitor your vital signs.

After Procedure

- You will have 2 small incisions. One is approximately 2" long and located in the upper buttocks where the implant battery (neurostimulator) is placed under the skin. The other is a ¼" incision about 3" above the tip of your tailbone where the small wire (lead) is placed under the skin.
- Both incisions are closed with absorbable suture, which do not have to be removed.
- Steri-strips (small band-aids) are applied to both and covered with a clear sterile dressing.

After Leaving

- You may shower the day after the procedure, but do not submerge incisions in water (no baths, no swimming, etc.) for at least 2 weeks after procedure.

Medications

- Dr. Taylor will prescribe two medications—a pain medication and an antibiotic.
- You may want to purchase an over-the-counter stool softener (such as Colace®).
- Ensure you have Tylenol® at home. Many patients report it is sufficient for pain relief.

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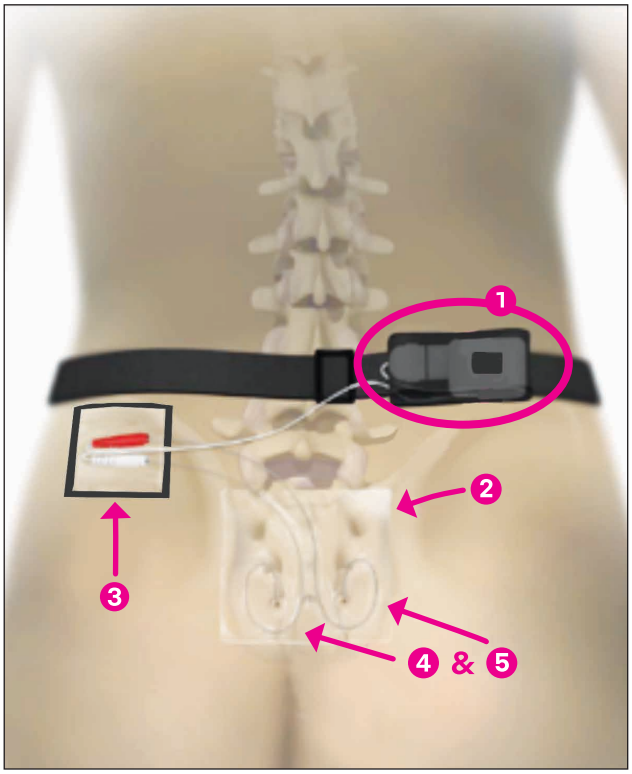
Removing InterStim® Test Leads



1. **Unplug the external stimulator** by detaching the white cord from the external stimulator, which is in the small pouch on the black elastic belt. You may discard the belt and external stimulator.
2. **Remove all 3 layers of tape** by peeling from one of the top corners and working your way down. It's not required, but some patients find that wetting the tape/bandages with a wet washcloth helps loosen them.
3. Once tape is removed, **peel off the black grounding pad** from the skin.
4. Sometimes, one or both of the leads (thin wires) come out of the skin when the final layer of tape is removed. If one or both are still in place, **remove the wires one at a time by grasping the wire right next to the skin and slowly pulling straight out**. Each wire only extends a couple of inches below the skin, but it may "uncoil" as it is removed, which makes it look longer. If the wire begins to uncoil, just re-grip the wire right by the skin and continue to pull outward until it is completely removed from the body. Some patients feel a slight discomfort as the wires are removed, but most report feeling no discomfort at all.
5. **Once the first wire is removed, repeat for the other wire.**
6. Everything except the Samsung® remote control is single-use and may be disposed of, including the elastic belt, white external stimulator, and all cables.
7. If any sticky residue remains from the tape, rubbing alcohol is helpful in removing it.

Returning the Samsung® Remote Control

Please bring the Samsung® remote when you return to the clinic for the implant procedure. If you are unable to return for the implant procedure, please follow the instructions in the bottom of the white box to mail it back to the clinic.

Please don't hesitate to call us if you need assistance with lead removal or have questions!

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Surgical Consents

The following pages are samples of the surgical consents you will be asked to sign on the day of the InterStim® implant procedure. Please review them in advance and please don't hesitate to call if you have any questions.

InterStim® Therapy for Bladder and Bowel Control Consent

Describes InterStim® therapy, its desired effects and potential complications, and the education and instruction you have received regarding the therapy. This is the consent you will sign authorizing Dr. Taylor to perform the InterStim® Therapy for Bladder and Bowel Control procedures.

Information and Consent for Anesthesia

This is the consent you will sign authorizing the use of anesthesia (typically IV sedation and local anesthetic) for the procedure.

Consent for Transfer

This form states you are aware this procedure is being performed in a Medicare-certified ambulatory surgery center licensed by the Arkansas State Health Department. We provide services for outpatient procedures and care only. In the unlikely event you should need extended care, you would be transferred to a hospital setting.

Acknowledgment

This is an acknowledgment that you have received, read, and understood this pre-operative instruction packet and any questions and concerns have been addressed.

Release Discharge Form

This is an acknowledgment that you have arranged for someone to drive you home (spouse, friend, one of our drivers, etc.), you have someone to stay with you at home, and you have received your discharge instructions. Your "Escort" or "Driver" will also be asked to sign this form.

Patient Rights

This form provides a list of your rights as a patient at our facility.

Please Note: These sample consents are for your review only. You do not need to sign them. You will be asked to sign the actual consents on the day of the procedure.

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CHRIS TAYLOR, MD
PATIENT INFORMED CONSENT FOR INTERSTIM® THERAPY FOR BLADDER AND BOWEL CONTROL

It is valuable and necessary that you understand the information contained in this informed consent document. This consent is meant to bring to your attention that medical procedures of any type, including the treatment you consent to today, come with inherent risks. Understanding the effect of this document, I, _____ hereby consent to the **InterStim® Therapy for Bladder and Bowel Control** procedure(s) described more fully below, to be performed by Dr. Chris Taylor, and his associates, assistants, appropriate ambulatory surgery center and clinic personnel on _____, 20_____.

The proposed procedure(s) are the **InterStim® Therapy for Bladder and Bowel Control** trial and implant for the treatment of one of the following: non-obstructive urinary retention, the symptoms of overactive bladder, including urinary urge incontinence and significant symptoms of urgency-frequency alone or in combination, when more conservative treatments fail or cause intolerable side-effects, or chronic fecal incontinence in patients who have failed or are not candidates for more conservative treatments. This therapy is not intended for patients with mechanical obstruction such as benign prostatic hypertrophy, cancer, or urethral stricture.

The procedure(s) have been explained in terms understandable to me, which explanation has included:

1. I have received education regarding normal bladder function, what is known about overactive bladder (OAB), and the risks and benefits of available treatment alternatives.

2. I understand that treatment of OAB includes first line therapies (behavioral therapies). These include, but are not limited to, limiting fluid intake, caffeine restriction, delayed or scheduled voiding, wearing protective garments, and pelvic floor exercises. Second line therapies (pharmacologic management) include OAB medications. These include, but are not limited to, oxybutynin (Ditropan®), tolterodine (Detrol®), darifenacin (Enablex®), solifenacin (Vesicare®), and mirabegron (Myrbetriq®). First and second line therapies are sometimes called conservative therapies. Third line therapies (advanced therapies) include sacral nerve stimulation (Interstim®), intra-detrusor onabotulinumtoxinA (Botox®) injections, and peripheral tibial nerve stimulation (PTNS).

3. I acknowledge that Dr. Taylor has discussed all options for therapy with me including continuing without treatment, continuing or starting conservative therapies, or continuing or starting other advanced therapies.

Patient Initials _____

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CHRIS TAYLOR, MD
PATIENT INFORMED CONSENT FOR INTERSTIM® THERAPY FOR BLADDER AND BOWEL CONTROL (CONTINUED)

4. I have failed conservative therapies for OAB or am unable or unwilling to take OAB medication and desire to proceed with an advanced therapy in the form of sacral nerve stimulation.

5. I understand that the symptoms of OAB include urgency, with or without urge incontinence, usually with frequency and nocturia.

6. I understand that InterStim® Therapy does not treat Stress Urinary Incontinence (SUI).

7. I understand that Dr. Chris Taylor is a provider of InterStim® Therapy, but not the only provider who offers this therapy.

8. I understand that both urologists and gynecologists can treat OAB and I understand that Dr. Taylor is a gynecologist.

9. I understand that a successful trial of InterStim® Therapy includes a > 50% improvement in one or more of my bladder or bowel symptoms.

10. I understand that a successful trial is a predictor of long-term improvement in my bladder or bowel symptoms but is not a guarantee of long-term improvement in my bladder or bowel symptoms.

11. I understand that symptom relief may vary from patient to patient and over time in a single patient. InterStim® Therapy has been shown to be an effective treatment for the symptoms of certain bladder and bowel issues. However, it is not a cure.

12. I understand that potential adverse events include pain at the implant sites, new pain, lead migration, infection, technical or device problems, adverse change in bowel or voiding function, and undesirable stimulation or sensations, including jolting or shock sensations.

13. I understand that the neurostimulator will need to be surgically replaced from time to time as the battery life will be depleted at some point in time.

14. I understand that potential adverse events could lead to the required need for a surgical revision, replacement, or removal of the device.

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CHRIS TAYLOR, MD
PATIENT INFORMED CONSENT FOR INTERSTIM® THERAPY FOR BLADDER AND BOWEL CONTROL (CONTINUED)

15. I understand that the system may be affected by or adversely affect cardiac devices, electrocautery, defibrillators, ultrasonic equipment, radiation therapy, MRI, and theft detectors/ screening devices.

16. I understand that while every effort will be made to ensure my comfort during the procedure, I may still experience some discomfort or awareness.

17. I acknowledge I was given the opportunity to ask questions and any questions and/or concerns have been answered to my full satisfaction.

18. To get the best results, adjustments to stimulation or reprogramming may be necessary.

19. My decision to undergo this treatment is one I made after careful consideration and is my own independent decision.

20. I consent to this treatment as well as any different treatment which may be indicated during the course of this treatment or due to any emergency.

21. I understand that fluoroscopy (continuous x-ray) will be used during my procedure. X-ray exposure will be kept as low as possible and the risk of harm from this amount of radiation is small and not expected to result in any adverse health effects. The known risks of radiation exposure include possible increased lifetime incidence of cancer, harm to an unborn fetus, and local skin reactions. Rarely, second degree burns have occurred during fluoroscopy.

22. I give permission for observers in the operating room and I agree to the taking of images, photographs or video of the procedure that my doctor deems necessary for medical, educational, treatment, or informational purposes.

23. I understand Chris Taylor, MD has made no assurance or guarantee to me as to any result I can expect regarding any procedure or treatment. I understand I am the only person that can ask for other options or clarifications of any procedure or treatment option presented by Chris Taylor, MD and I am free to accept or refuse the option(s) presented by my physician or to seek a second opinion. By signing below, I accept, for myself and/or my ward, all risks of, and financial responsibility for, the procedures/treatment and any other services rendered by Chris Taylor, MD.

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CHRIS TAYLOR, MD
PATIENT INFORMED CONSENT FOR INTERSTIM® THERAPY FOR BLADDER AND BOWEL CONTROL (CONTINUED)

MY SIGNATURE BELOW CONFIRMS THAT: (1) I HAVE READ AND UNDERSTAND THE RISKS, BENEFITS, AND OTHER INFORMATION SET OUT IN THIS DOCUMENT; (2) I HAD A CHANCE TO ASK MY DOCTOR QUESTIONS AND I HAVE RECEIVED ALL OF THE INFORMATION I DESIRE CONCERNING ANY TREATMENT/PROCEDURE; AND (3) I AUTHORIZE AND CONSENT TO THE PERFORMANCE OF EXAMINATION/DIAGNOSIS/TREATMENT/PROCEDURES FOR MYSELF, OR FOR MY DEPENDENT/WARD.

Patient: _____

Printed Name: _____ Date: _____ Time: _____

Witness to Signature: _____

Printed Name: _____ Date: _____ Time: _____

Dr. Taylor: _____

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CHRIS TAYLOR, MD
INFORMATION AND CONSENT FOR ANESTHESIA

It is important that you, the patient, read this consent form carefully. If you have any questions after reading this form, they may be directed to the anesthesia provider the day of your procedure.

For your upcoming procedure by Dr. Chris Taylor, a fully licensed and qualified anesthesia provider will administer your anesthesia. This CRNA (Certified Registered Nurse Anesthetist) or an Anesthesiologist will be with you during all phases of your anesthetic. Our goal is to provide a safe and comfortable experience for you.

Modern anesthesia is safe and usually well tolerated. However, even in experienced and competent hands, any type of anesthesia or pain relief carries a risk and complications can occur. Although in most cases the risks are extremely small, in order for you to make an informed decision, you need to be aware that death or serious bodily injury can occur during anesthesia. Some types of health problems increase the risk of complications, so it is important that we review with you the health history questionnaire that you previously completed.

Complications involving the lungs can occur after a procedure and anesthesia. Atelectasis (collapsing of the small air sacks) or pneumonia can occur. Aspiration of stomach contents into the lungs can cause serious illness or death. Therefore, to help prevent this from occurring, **IT IS MANDATORY THAT YOU DO NOT EAT OR DRINK ANYTHING WITHIN SIX (6) HOURS BEFORE YOUR PROCEDURE,** unless otherwise directed.

Intravenous (IV) catheters are started on all patients going into a procedure. This allows for the administration of some anesthetics and fluids. Sometimes veins become infected and blood clots can occur. The skin may react to the tape or nerve damage may occur due to the arm being positioned in one place for a prolonged period.

RISK: I understand that risks are associated with anesthesia, many of which are listed below.

- Nausea and vomiting
- Headache
- Hoarseness of voice
- Cuts and bruises to face and mouth
- Sore throat and pharynx
- Damage to teeth, caps, bridges and gums
- Distension from gases in stomach, intestines or other tissues
- Urinary retention
- Temporomandibular joint (TMJ) injury
- Temporary paralysis (weakness)
- Failure of a local anesthetic procedure
- Awareness during surgery
- Inhalation of stomach contents
- Air in the tissues, including Pneumothorax
- Adverse drug reactions including anaphylaxis
- Corneal abrasion or other eye injury
- Pneumonia
- Pulmonary embolus (blood clot in the lung)
- Heart attack or other cardiac morbidity
- Nerve injury causing pain, weakness or loss of sensation
- Stroke—cerebral vascular accident (CVA)
- Injury to any organ system in the body
- Bleeding
- Failure to recover or wake up
- Birth defect, from drugs given during pregnancy
- Loss of life

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CHRIS TAYLOR, MD
INFORMATION AND CONSENT FOR ANESTHESIA (CONTINUED)

In rare instances, anesthesia agents can cause high fevers. Injury can occur to teeth or dental work when instruments are used to visualize the larynx during placement of breathing tubes or other airway devices. Anesthesia drugs, both for general or local anesthesia, can cause your heart or lungs to stop. In addition, drugs can cause damage to the kidneys or liver. Local anesthetics can cause direct damage to nerves. Headaches, numbness, bleeding and paralysis can result from nerve blocks. An inadvertent injection of local anesthesia into the circulation can cause convulsions and shock. Awareness during anesthesia is rare but can occur.

With general anesthesia, sore throat is common. Most patients can expect to feel cold when they awaken, have some slight discomfort and be drowsy. Patients tolerate this type of anesthesia well, usually with minimal problems. Having listed most of the complications of anesthesia to help you make an informed decision, please be assured that the possibility of a major complication is remote. Your anesthesia provider is a highly trained and skilled person who will be monitoring your health throughout the procedure. Your anesthesia provider will talk with you prior to your procedure to discuss with you in detail your anesthesia care.

I agree to the administration of one or more of the following forms of anesthesia, which may be suitable for the procedure I am about to have. While I understand that the type(s) of anesthesia checked below is intended to be used for my procedure, it has also been explained to me that sometimes an anesthesia technique, which involves the use of local anesthetics, may not succeed. I therefore, consent to an alternative type of anesthesia, including general anesthesia, if necessary, as deemed appropriate by the anesthesia team.

(Please check anesthetic technique below.)

_____ A) GENERAL ANESTHESIA/TOTAL INTRAVENOUS ANESTHESIA: including intravenous agents and inhaled gases, which will cause unconsciousness.

_____ B) MONITORED ANESTHESIA: including injections into the intravenous line, breathing by facemask, or by other means, producing a semiconscious state.

_____ C) LOCAL ANESTHESIA: including local anesthetics with or without intravenously administered sedatives.

_____ D) TUMESCENT ANESTHESIA: including injection of large quantities of very diluted lidocaine (local anesthetic) and epinephrine (capillary constrictor) into the subcutaneous fat.

1. I hereby authorize the administration of anesthesia as deemed necessary for my surgical procedure.
2. I acknowledge that I have been given an explanation of and an opportunity to ask questions about the anesthesia to be used and the risks and hazards involved, any alternative forms of anesthesia, and the risks of non-treatment. I believe I have sufficient information to give this informed consent.

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CHRIS TAYLOR, MD
INFORMATION AND CONSENT FOR ANESTHESIA (CONTINUED)

3. I certify that this form and the information which it contains or describes has been fully explained to me, that I have read it, or had it read to me, that I understand its contents, and that all blanks have been filled in prior to my signing.
4. Because the anesthetic medication (including oral pre-medication/sedation) causes prolonged drowsiness, I must be accompanied by a responsible adult to drive me to and from surgery and stay with me for several hours until I am recovered sufficiently to care for myself. Sometimes the effects of the drugs do not wear off for 24 hours.
5. During recovery time (normally 24 hours for general anesthesia and 12 hours for IV sedation), I understand that I should not drive, operate complicated machinery or devices, or make important decisions such as signing documents.
6. I must have a completely empty stomach. It is vital that I have **NOTHING TO EAT OR DRINK FOR 6 HOURS PRIOR** to my anesthetic. **TO DO OTHERWISE MAY BE LIFE THREATENING**. (Note: If directed by my doctor, sips of water may be used to take regular medications or prescriptions given to me by this office).

When did you last have anything by mouth? Date: _____ Time: _____ am/pm

What did you have? _____

I have read and understand the above paragraphs and realize that anesthesia carries with it certain serious risks. I request that anesthesia be used for my surgery. All my questions regarding this consent have been answered fully to my satisfaction, and I fully understand the risks involved. I do not request hospitalization for my anesthetic. I certify that I speak, read and write English.

_____ _____

Patient (or legal guardian) Signature Nurse

I hereby certify that I've explained the nature, purpose, benefits, risks and alternatives to the proposed anesthetic patient. I have encouraged the patient to ask questions and have answered such questions. I believe that the patient/authorized representative understands what I have explained and is satisfied with all questions answered.

_____ _____

Anesthesia Provider Doctor

_____

Date

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CHRIS TAYLOR, MD
CONSENT FOR TRANSFER

1. I understand that my surgery is being performed at Dr. Chris Taylor's outpatient surgery center. I understand that this outpatient surgery center is Medicare approved and licensed by the Arkansas State Health Department.

2. I recognize that during the course of my surgery and/or recovery, unforeseen conditions may necessitate the transfer and/or admission to another medical facility or hospital.

3. I fully understand that additional costs may occur should complications develop from my surgery. Any additional or secondary surgical fees, hospital charges, ambulance services, laboratory fees, wound care charges, anesthesia fees, pathology fees or any other long-term medical care cost will be solely my responsibility.

4. I also agree to the transfer or sharing of my medical records with another facility if deemed necessary by Dr. Chris Taylor during the course of my care.

By my signature below, I acknowledge this consent for transfer and accept this risk.

Patient: _____

Printed Name: _____ Date: _____ Time: _____

Witness to Signature: _____

Printed Name: _____ Date: _____ Time: _____

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CHRIS TAYLOR, MD
ACKNOWLEDGMENT

We have outlined the common and not-so-common risks of surgery in general. The specific risks and complications of each surgical procedure have been explained elsewhere in this pre-operative packet. We have not discussed every possible problem that may occur, and you cannot assume that a problem will not occur simply because it is not discussed here.

I acknowledge that the risks and complications of the surgery I am to undergo have been explained and discussed with me in detail by Dr. Taylor and his staff. I have been given the opportunity to ask questions and any concerns I had about my surgery have been explained to me.

I have received and thoroughly reviewed a pre-operative packet specific to my surgery. I acknowledge a complete understanding of its contents and feel that I have been appropriately consented by Dr. Taylor and his staff.

By my signature below, I acknowledge and accept this information.

Patient: _____

Printed Name: _____ Date: _____ Time: _____

Witness to Signature: _____

Printed Name: _____ Date: _____ Time: _____

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CHRIS TAYLOR, MD
RELEASE DISCHARGE FORM

TO BE COMPLETED BY PATIENT PRIOR TO SURGERY

I, _____, will undergo the following surgical procedure(s) by Dr. Chris Taylor.

Procedure(s): _____

- This procedure will be performed in conjunction with an anesthesia provider.
- I will speak to either Dr. Taylor or my anesthesia provider subsequent to my recovery. He/she will ensure that I am feeling well and I am able to be discharged from the surgical center.
- I may or may not remember the conversation with Dr. Taylor or the anesthesia provider due to the aftereffects of the anesthesia. However, I will not be discharged from the surgical center until I certify that I am feeling well enough to be released.
- I have arranged for an escort, listed below, to take me home and I also have arranged to have someone stay with me during the immediate post-operative period.
- I have been given full post-operative instructions; I understand them and have been given every opportunity to ask questions.

Patient: _____

Printed Name: _____ Date: _____ Time: _____

Witness to Signature: _____

Printed Name: _____ Date: _____ Time: _____

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CHRIS TAYLOR, MD
RELEASE DISCHARGE FORM (CONTINUED)

TO BE COMPLETED BY ESCORT BEFORE DISCHARGE

I, _____, am the escort arranged by the patient. I find the patient to be reasonably alert and oriented as to time, date and place. I am able to assist the patient home. I believe that the patient desires to be released and is not being rushed to leave by any member of the surgery center staff.

Escort: _____

Printed Name: _____ Date: _____ Time: _____

Witness to Signature: _____

Printed Name: _____ Date: _____ Time: _____

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CHRIS TAYLOR, MD
PATIENT RIGHTS

Each patient treated at this facility has the right to:

1. Be treated with respect, consideration, and dignity.
2. Respectful care given by competent personnel with consideration of their privacy concerning their medical care.
3. Be given the name of their attending physician, the names of all other physicians directly assisting in their care, and the names and functions of other health care persons having direct contact with the patient.
4. Have records pertaining to their medical care treated as confidential.
5. Know what surgery center rules and regulations apply to their conduct as a patient.
6. Expect emergency procedures to be implemented without necessary delay.
7. Be informed of the clinic and surgery center's Policy on Advanced Directives.
8. The absence of clinically unnecessary diagnostic or therapeutic procedures.
9. Expedient and professional transfer to another facility when medically necessary and to have the responsible person and the facility that the patient is transferred to notified prior to transfer.
10. Treatment that is consistent with clinical impression or working diagnosis.
11. Good quality care and high professional standards that are continually maintained and reviewed.
12. An increased likelihood of desired health outcomes.
13. Full information in layman's terms concerning appropriate and timely diagnosis, treatment, and preventive measures. If it is not medically advisable to provide this information to the patient, the information shall be given to the responsible person on his/her behalf.
14. Receive a second opinion concerning the proposed surgical procedure, if requested.
15. Accessible and available health services and information on after-hour and emergency care.
16. Give an informed consent to the physician prior to the start of a procedure.

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CHRIS TAYLOR, MD
PATIENT RIGHTS (CONTINUED)

17. Be advised of participation in a medical care research program or donor program; the patient shall give consent prior to participation in such a program. A patient may also refuse to continue in a program she has previously given informed consent to participate in.

18. Receive appropriate and timely follow-up information of abnormal findings and tests.

19. Receive appropriate and timely referrals and consultation.

20. Receive information regarding "continuity of care."

21. Refuse drugs or procedures and have a physician explain the medical consequences of the drugs or procedures.

22. Appropriate specialty consultative services made available by prior arrangement.

23. Medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability, or source of payment.

24. Have access to an interpreter whenever possible.

25. Be provided with, upon written request, access to all information contained in their medical record.

26. Accurate information regarding the competence and capabilities of the organization.

27. Receive information regarding methods of expressing suggestions or grievances to the organization.

28. Appropriate information regarding the absence of malpractice insurance coverage.

29. Change primary or specialty physicians if other qualified physicians are available.

30. Health services provided that are consistent with current professional knowledge.

31. Patients, patients' families, and visitors to the Surgery Center may file a verbal complaint with a supervisor on duty or they may file a formal written complaint with suggestions to clinic and/or surgery center administration. (Complaint forms are available upon request.)

Patient Initials _____

Dr. Chris Taylor
www.drchristaylor.com

1425 Rock Springs Road
Harrison, AR 72601

Phone: (870) 741-1616
Fax: (870) 741-2211

Chris Taylor, MD

- 20+ Years Treating Female Bladder Problems
- 2,500+ Sacral Nerve Stimulation Procedures Performed
- 25,000+ Women Treated
- 10,000+ Seminar Attendees Educated
- #1 Global Provider of Sacral Nerve Stimulation Therapy

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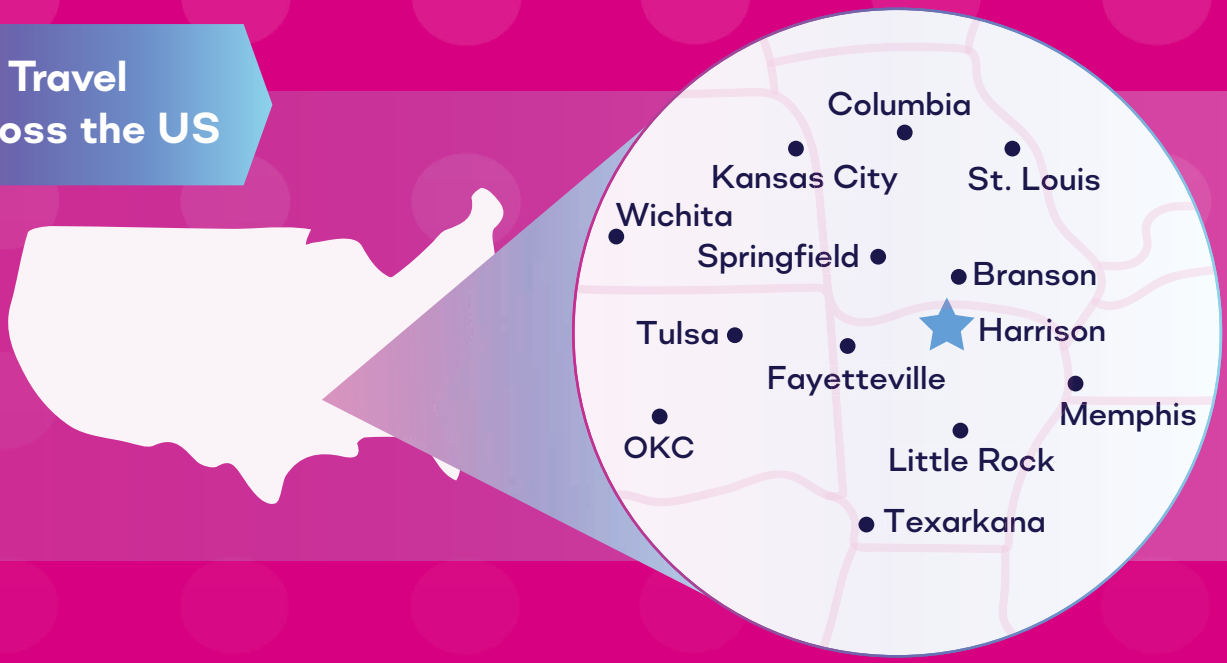
Patients Travel from Across the US



★ Dr. Taylor's facility is located in Harrison, Arkansas, just 20 minutes south of Branson, Missouri

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