ATTACH PATIENT LABEL HERE

Informed Consent to Treat and Disclose Information

To Our Patient:
You have the right as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be performed so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby consent to the performance of operations and procedures in addition to or different from those now planned whether or not arising from presently foreseen conditions, which the doctor named below or his associates or assistants may consider necessary or advisable during the operation or procedure.

I voluntarily request Dr. ______________________________ as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition. I understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I voluntarily consent and authorize those procedures:

(Initials)

______I ☐**(do)** ☐**(do not)** consent to the transfusion of blood, blood components as deemed necessary.

______I ☐**(do)** ☐**(do not)** consent to the disposal of any tissues or body parts that may be removed in accordance with customary practice.

______I ☐**(do)** ☐**(do not)** authorize my doctor and/or such assistants as he/she may select to photograph or video tape me. I understand that the photographs/video will be used only for medical and educational purposes and will not be released for publication in any other context without my expressed written permission.

______For the purpose of advancing medical education, I ☐**(do)** ☐**(do not)** consent to the admittance of students and persons required for technical support to the room in which the procedure is performed.

______I understand that I am scheduled to go home after my surgery and I must have a responsible adult drive me home and stay with me as advised by my physician.

______I understand the surgery is intended to be performed on an outpatient basis.
I consent to my transfer to a hospital or other facility should my physician(s) deem it advisable or necessary.

______The nature, purpose, and possible complications of the procedure and medical services described above; risks and benefits reasonably expected; and the alternative methods of treatment have been explained to me by the physician; and I understand the explanation I have received.

Continued on Page 2

ATTACH PATIENT LABEL HERE

______I understand the Surgery Center is not responsible or liable for the loss of or damage to any article of value that I brought to the center.

______I have received and understand this center's Notice of Privacy Practices.

______Consent to Administration Anesthetics. I acknowledge that I have authorized and directed, the assigned anesthesiologist/physician to administer anesthetics to me in connection with the operation or diagnostic procedure. The physician has explained to me the nature of these anesthetics, the way they will be given to me, their usual effects, and the substantial hazards and risks in connection with their use.

______Consent to Other Medical Services. I hereby authorize and direct the above-named physician, dentist or podiatrist and/or his/her associates or assistants to provide such additional services for me as he, she or they may deem necessary or advisable, including, but not limited to, the performance of services involving pathology, anesthesia and/or radiology, and I hereby consent to all such additional services.

______Relationship between Practitioners and Facility. I understand and agree that all practitioners who furnish services to me at the Facility, including my physician, dentist, or podiatrist and the pathologist, anesthesiologist and the like, are independent contractors with me and are not employees or agents of the Facility. I further understand and agree that I am under the care and supervision of my attending physician, dentist or podiatrist, and it is the responsibility of the Facility and its nursing staff to carry out the instructions of such physician, dentist or podiatrist.

In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated in the Surgery Center's price list (known as the "Charge Master") effective on the date of service, which rates are hereby expressly incorporated by reference as the price term of this Agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or the charge is listed as zero. In the event that the Surgery Center has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to herein, the undersigned agrees to the attorney's fees and collection expenses incurred by the Surgery Center.

An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Surgery Center. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

ATTACH PATIENT LABEL HERE

We may use or disclose information about you to bill or receive payment for medical treatment or services provided to you. These disclosures include releasing information;

(1) to your health plan to obtain prior approval or to determine whether your plan will cover the treatment or services; or

(2) to individuals or entities involved in collecting amounts owed to us.

Signature ____

Patient Date Witness Time

(if the patient is a minor or unable to sign, complete the following)

- ☐ Patient is a minor
- ☐ Patient is unable to sign because ______________________________

____

____

Patient Parent Legally Designated Representative

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name ____

Name ____

Name ____

Signature of patient ____