PLAZA
Ambulatory Surgery Center, LLC

PATIENT LABEL

INFORMED CONSENT TO OPERATION AND OTHER PROCEDURES

PATIENT NAME	DOB	DATE	SURGEON
PROPOSED PROCEDURES			

1. The facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of the facility, but independent contractors and, therefore, are the patient's agents or servants. The facility provides nursing and support services and facilities; the facility does not provide medical physician care.
2. The procedure(s) listed to be performed and the advantages and disadvantages, risks and possible complications as well as the alternatives and risks and possible complications of the alternatives have been explained to me by my physician. The doctor has satisfactorily answered my questions.
3. My consent is given with the understanding that any operation or procedure involves risks and hazards. The more common risks include: infection, bleeding with the need for blood transfusion, nerve injury, blood clots, heart attack, stroke, allergic reaction, damage to teeth or bridgework, and pneumonia. These risks can be serious and possibly fatal.
4. I authorize and direct the above named surgeon to arrange for such additional services for me as he or she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia, which may include general, regional or sedation, and the performance of pathology and radiology services, to which I hereby consent.
5. I am aware that prior to my procedure the Anesthesiologist will review the anesthesia plan with me which includes alternatives, risks and benefits. I will have the opportunity to ask questions and make decisions in regards to my care.
6. I authorize the pathologist or physician to use his or her discretion in disposing of any member, organ, implant, prosthetic, or other tissue removed from my person during the operation(s) or procedure(s).
7. The facility may participate in residency and other training programs for physicians, allied health professionals and other providers of services. All care rendered by individuals in training will be supervised and reviewed, as appropriate, by appropriate personnel. I hereby consent to care and treatment from individuals in training and to the review of my patient record by same.
8. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV and Hepatitis.
9. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me following my surgery. I acknowledge that I have been advised by facility personnel not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until the day after my surgery/procedure or as directed by my physician.
10. I hereby consent to the presence of the other person(s) for the sole purpose of observation and /or education. I understand that this individual(s) will not participate in the actual procedure.
11. I consent to the use of video-taping or photography that may be used for scientific or teaching purposes, and to the review of my medical record for bona fide medical healthcare research providing my name or identity is not revealed.
12. I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility.
13. I understand that if I am pregnant or if there is any possibility I may be pregnant, I must inform the facility immediately since the scheduled procedure could cause harm to my child or to myself.
14. I understand that in the rare event that hospitalization is required during or immediately after surgery, my physician will arrange for my transfer to a local hospital.
15. I understand that it is the policy of this surgery center not to administer blood. In the rare event that I need a blood transfusion I will be transferred to a local hospital where I can give my consent regarding receiving blood.
16. I have not eaten or taken fluids, not even water, since DATE _____ TIME _____AM / PM except for a sip of water taken with medication as instructed by my physician.
17. My signature below constitutes my acknowledgment that (1) I have read or have had read to me the foregoing, and I agree to it: (2) the procedure(s) has been adequately explained by my physician; (3) I authorize and consent to the performance of the procedure(s) and any additional procedure(s) deemed advisable by my physician in his or her professional judgment; (4) I authorize and consent to the administration of anesthesia for the said procedure(s).
18. If I am not the patient, I represent that I have the authority of the patient who, because of age or other legal disability, is unable to consent to the matters above. I have full right to consent to the matters above, and I consent to same; (b) I hereby indemnify and hold harmless the facility, its employees, agents, medical staff, partners and affiliates from any cost or liability arising out of my lack of adequate authority to give this consent.

DATE _____ TIME _____ PATIENT'S SIGNATURE _____

DATE _____ TIME _____ WITNESS SIGNATURE _____

DATE _____ TIME _____ PHYSICIANS SIGNATURE _____

If the patient is a minor or unable to sign complete the following:
□ PATIENT IS A MINOR □ PATIENT IS UNABLE TO SIGN

DATE _____ TIME _____ SIGNATURE _____ RELATIONSHIP _____

DATE _____ TIME _____ WITNESS SIGNATURE _____