FELLOWSHIP SURGICAL CENTER **FACILITY CONSENT FORM**

PATIENT NAME ACCOUNT RECORD SURGEON DATE OF SERVICE

DATE OF BIRTH AGE M/F

CONSENT TO TREATMENT AND RENDERING OF OTHER MEDICAL SERVICES, INCLUDING CONSENT FOR TRANSFUSION, BLOOD TESTING, AND RELEASE OF MEDICAL RECORDS

We are required to obtain your consent for your planned surgery/medical procedure. What you are being asked to sign is a confirmation that your doctor has discussed the nature and purpose of the surgery/medical procedure and the risks and benefits associated with it. Except in cases of emergency, surgery/medical procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or to refuse any of the care or treatment. You have the right to consent to or to refuse any proposed surgery or medical procedure at any time prior to its performance. By reading and signing this document, you agree to the following:

1. I understand that medical procedures and operations may involve risks, unsuccessful results, serious complications, injury, or even death, from both known and unknown causes, and no warranty or guarantee of success has been made regarding results or cures.

2. My doctor has explained the nature of the surgery/medical procedure, the risks and benefits, possible complications, expected benefits or effects, and alternative treatment available to me and has answered all the questions that I asked. The information has been presented in a clear manner that I understand.

3. Except in cases of emergency, operations or procedures will not be performed until I have had the opportunity to receive this information and have given my consent.

4. I authorize my doctor to perform any other incidental/minor surgery or medical procedure that, in his/her judgment is medically necessary for my well-being. In some cases, my doctor will not be able to identify ahead of time just what the additional surgery/medical procedure might be. I understand this. If there are surgeries or procedures that I do not want performed, I have informed my doctor.

5. I authorize my doctor to use additional associates, assistants, or other healthcare providers to assist with my surgery/medical procedure. My doctor may also assign or request additional assistance from anesthesiologists, other anesthesia providers, licensed medical residents in training or others who perform specialized medical care and treatment. My doctor has explained their role and involvement in my care and treatment.

6. I understand that the persons who perform these specialized medical services, such as anesthesia, radiology or pathology, are independent contractors and are not agents or employees of the facility or my doctor. Since they are independent contractors, the facility is not responsible or liable for acts or omissions.

7. I understand that the facility maintains personnel and equipment to assist my doctor with surgical operations and other special diagnostic or therapeutic procedures. I consent to use the facility’s staff and equipment for my care.

8. I authorize the presence of approved observers for my surgery/medical procedure. This includes medical/nursing students; medical school residents/interns; medical company equipment specialists; and other healthcare students. My doctor has discussed this with me and explained their role in my surgery/medical procedure. I understand that I have a right to privacy and that I do not have to agree to their presence during my surgery/medical procedure.

9. I authorize the pathologist to use his/her discretion in disposing of any member, organ, or other tissue removed from my body during the surgery/medical procedure.

FELLOWSHIP SURGICAL CENTER **FACILITY CONSENT FORM (cont'd)**

PATIENT NAME ACCOUNT RECORD SURGEON DATE OF SERVICE

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10. I authorize the facility staff or my doctor to photograph or videotape my surgery/medical procedure and use the prints, negatives, or videotapes for purposes related to my healthcare, professional activities or medical education. My identity will not be shown, and the photos, negatives and videotapes will be the property of the doctor or the facility.

11. In case of an emergency, I authorize the facility and my doctor to transfer me to another health care facility if medically necessary for my care. I also consent to the release of my medical records to that facility and to other doctors who will continue my care.

12. In the event of a true life-threatening medical emergency, I authorize the transfusion of blood or blood products.

13. In the very rare event that a facility employee or health professional has accidental exposure to my blood or other body fluids (for example, they are stuck by a needle with my blood on it), I authorize the facility to draw blood for testing for the presence of HIV/AIDS or hepatitis. I know I will not be charged for this testing. If tests show the presence of these illnesses, the results will be forwarded to my personal physician for confidential medical follow-up and treatment if needed in order to protect my health and the health of my family. Additionally, the facility will offer medical care to the involved employees or healthcare professionals. All test results will be handled in a strictly confidential manner.

My signature below certifies (1) that I have read and understood the information provided in this form; (2) that the surgery/medical procedure has been adequately explained to me by my doctor; (3) that I have had a chance to ask questions; (4) that I have received all of the information I need concerning the surgery/medical procedure; (5) that I accept any substantial and significant risks of the procedure; and (6) that I authorize and consent to the performance of the surgery/medical procedure.

Date: _____ **Signature:** _____
(Patient/Parent/Conservator/Guardian)

Time: _____ **Witness:** _____