Patient Name: _____ Date of Birth:_____

Date of Surgery:_____ Medical Record #: _____

Admission Agreement, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic and Use and Disclosure of Protected Health Information with Beverly Oaks Physicians Surgical Center, LLC.

This agreement is intended to be written in plain English. If you do not understand any part, please ask us to explain it.

Patient name:_____ I authorize / direct my physician(s)and/or surgeon(s): _____
And/or both, to perform the following operation(s) and / or diagnostic procedure(s):

_____

It has been explained to me that during the course of the operation, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) set forth above. I therefore authorize and request that my surgeon and/or his associates or assistants, as he may delegate, perform such surgical procedures as are necessary and desirable in the exercise of their professional judgment.

I understand the nature of the operation(s) listed above, the expected benefits or effects of such operation(s), the medically acceptable alternative procedures or treatments. I have also been informed that in the performance of any surgical or invasive procedure there are risks and complications such as severe loss of blood, injury, infection, cardiac arrest, or even death. I am aware that the practice of medicine is not an exact science. I acknowledge that neither the surgical facility nor the physicians have made any guarantees as to the results that may be obtained or the consequences that may follow this operation(s).

Consent for Anesthesia: I understand the following types(s) of anesthesia may be used: General, Deep Sedation/analgesia, Moderate/Conscious Sedation, Regional, Local/ Topical

Patient/Authorized Representative Initials_____

Significant risks and complications of the anesthesia to he administered have been explained and include but are not limited to: sore throat, nausea, vomiting, upper respiratory infection, bronchitis, pneumonia, chipped teeth, cardiac arrhythmia, cardiac or respiratory arrest. I accept these risks and hereby consent to the administration of anesthetics No warranty or guarantee has been made as to the results thereof.

Following surgery, if conscious sedation and or general anesthesia were administered I will have a responsible person drive me home and I have made arrangements for this. I realize that impairment of full mental alertness may persist for several hours following the administration of conscious sedation anesthesia/general anesthesia and I will avoid making decisions or taking part in activities, which depend upon full concentration or judgment during that period.

Patient/Authorized Representative Initials_____

Consent to Transfer

I understand that the surgical and / or diagnostic procedure to be performed on me at this Center will be done on an outpatient basis and that the facility does not provide for 24-hour patient care. If my attending physician or any other duly qualified physician in his / her absence, shall find it necessary or advisable to transfer me from the facility to a hospital or other health care facility. I consent and authorize the employees of the facility to arrange for and affect the transfer.

I further consent to the release of my information pertaining to my medical care should admission to an acute care facility become necessary during or within 72 hours following my admission to the surgical center; I authorize my medical records from the admitting acute care facility to be released to the Center.

Patient/Authorized Representative Initials_____

Consent to Blood and/or Blood Products Transfusions

I understand that should I need blood or blood products, I will be transferred to an acute care hospital for the delivery of such.

**Advance directive** is a written document, which communicates your health care wishes clearly. There are two types of advance directive documents:

**A Durable Power of Attorney for Health Care:** Allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to, the withholding or withdraw of life prolonging procedures.

Patient Name: _____ Date of Birth:_____

Date of Surgery:_____ Medical Record #: _____

A Living Will or Health Care Directive: Allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

I have been explained the centers' policy on Advance Directives.

- ❑ I DO have an Advance Directive
- ❑ I have a "Do Not Resuscitate" Directive and agree to Resuscitation
- ❑ I do NOT have an Advance Directive

Consent to Resuscitation

This signed document implies consent for resuscitation and transfer to a higher level of care should the patient suffer a cardiac or respiratory arrest or other life-threatening situation. Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment (including resuscitative services). The right of self-determination may be effectuated by an advance directive.

Patient/Authorized Representative Initials_____

Tissue Disposal

I hereby authorize the pathologist to use his / her discretion in the disposal of any severed tissue member or organ removed from me during the operation or procedure described above

Patient/Authorized Representative Initials_____

Photographic Consent

I consent to the photographing and / or videos of the operation, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them.

Patient/Authorized Representative Initials_____

Consent to Test for Blood-Borne Diseases

I understand that it may be necessary to test my blood while I am a patient at this Center, in an effort to protect against possible transmission of blood-borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome. If, for example, a Center employee is stuck by a needle after giving an injection, starting an intravenous fluid, drawing blood, or sustains a scalpel injury, I understand that my blood as well as the employee's blood will be tested. I have been informed that the performance and results of the HIV antibody test are considered confidential. That the test results in my health record shall not be released without my written permission, except to the individuals and organizations that have been given access by law who are required to keep my health record information confidential.

Patient/Authorized Representative Initials_____

Patient Valuables / Personal Property

I have been instructed to leave valuables at home or place them in the care of family members. I understand and agree that the center shall not be liable for loss or damage to any personal property unless deposited with the center for safe keeping. The liability of the center for loss of any personal property so deposited is limited by statute to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the center by the patient.

Patient/Authorized Representative Initials_____

Consent to Use and Disclosure of Protected Health Information

My protected health information may be used by the Center or disclosed to others for the purposes of treatment, obtaining payment, or reporting the day-to-day health care operations of the practice. I have received a copy of the Centers Notice of Privacy Practices and agree that that the Center may use my information as provided in said policy. I understand that I may request a restriction on the use or disclosure of my protected health information. The Center may or may not agree to restrict the use or disclosure of my protected health information. If the Center agrees to my request, the restriction will be binding on the center. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. I may revoke this consent to the use and disclosure of my protected health information. I must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which my revocation of consent is received will not be affected. The Center reserves the right to modify the privacy practices outlined in the notice.

Patient/Authorized Representative Initials_____

Patient Name: _____ Date of Birth:_____

Date of Surgery:_____ Medical Record #: _____

Legal Relationship Between Beverly Oaks Physicians Surgical Center, LLC and Providers

I understand that all physicians furnishing services to the patient, including the anesthesiologist (or CRNA), pathologist, radiologist and the like, are independent contractors and are not employees or agents of the center.

Patient/Authorized Representative Initials_____

Payment Obligations

I authorize direct payment from my insurance company for certain costs for medical equipment, disposables (sterile supplies, etc) or services that may arise during the performance of the above operation(s) which may be billed collectively as a "facility fee" to my insurance company by the surgery center. The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of outpatient services, including emergency services if rendered, provided to the patient, he/she hereby individually obligates himself/herself to pay the account of the center in accordance with the regular rates and terms of the center. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Patient/Authorized Representative Initials_____

Certification

The undersigned certifies that he / she has read and understood this Admission Agreement, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic and Use and Disclosure of my Protected Health Information.
I understand that this is a continuing consent and is valid for a period of thirty (30) days from the date of my signature.

Date_____ Time_____a.m./p.m. Primary Language of Patient:_____

_____ X_____

Patient / Authorized Representative Name Patient / Authorized Representative Signature

X_____ Translator Name:_____ or NA

Witness Signature

_____ _____

If signed by other than patient, indicate relationship Language