PATIENT CONSENT FOR TREATMENT

Consent to Medical and Surgical Procedures: I give my consent to all the medical procedures which may be performed upon me by the Hospital, on either an inpatient or outpatient basis, which are ordered or prescribed for me by my attending physician. This may include but is not limited to: laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me under the general and special instructions of my physician.

Consent to Imaging/Diagnostic Procedures: I give my consent if the attending physician believes it is beneficial for me to undergo one or more of the following exams that produce ionizing radiation: diagnostic X-rays, Computed Tomography (CT), and the use of Fluoroscopy while undergoing an injection, surgical or pain procedure. Although both short and long-term risks are present with radiation exposure, this rarely results in significant short or long-term injury. In complex cases, local tissue damage to the skin or even underlying layers may occur that may require additional follow-up treatment.

Consent to Draw Blood/Emergency Procedures: I hereby consent to the withdrawal of a blood sample in the event an employee or contractor of the hospital has a needle stick or mucous membrane exposure to my blood or body fluids. I further consent to the medical treatment from a licensed physician in the event of a highly urgent or emergency event in which the patient, a family member, or other responsible party cannot reasonably be reached to authorize treatment.

Authorization for Use or Disclosure of Protected Health Information (*please initial and check choice, if applicable***)**

_____ I hereby □ DO or □ DO NOT authorize the use of audio/video record or broadcast of my surgery and disclosure of individually identifiable health information relating to me as described below.

_____ I further □ DO or □ DO NOT authorize physical observation of my surgery by medical personnel and appropriate manufacturer's representatives or other observers as determined by my physician.

_____I (we) authorize my surgeon the use of photographs in the interest of my medical record.

- The above information will be called "*Authorized Information*" throughout the rest of this Authorization.
- The *Authorized Information* will be used by the physician performing my surgery and by other individuals as determined by my physician.
- The *Authorized Information* can be disclosed for informational and/or instructional purposes.
- This *Authorized Information* can be used when all identifying information have been removed, to instruct in a clinical environment or for research purposes in accordance with applicable privacy rules.
    - I understand that if the person or entity receiving *Authorized Information* is not a health plan or health care provider covered by federal privacy regulations, the *Authorized Information* may be re-disclosed by the recipient and may no longer be protected by federal or state law.
    - I understand that I may revoke this authorization at any time by notifying the Business Office Manager of North Central Surgical center in writing. However, if I choose to do so, I understand that my revocation will not affect any disclosure allowed by this Authorization before the receipt of my revocations.
    - I understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my treatment.

Release of Information: I authorize the Hospital and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this admission or outpatient visit to any organization which is or may be liable or responsibly for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work-related, I authorize the Hospital to release any information from my medical records to my employer and/or its designee.

In compliance with the State Medical Device Act of 1990, if an FDA designated medical device is implanted during surgery, I (we) understand that my Social Security number and name will be released to the manufacturer.

_____ I (we) understand that my name and procedure will be posted on the OR Scheduling board in a private area of the Operative Suite.

DO YOU HAVE ADVANCE DIRECTIVES? □ Yes □ No If yes, where is it located? _____

_____ I (we) understand that in the event surgery is performed and circumstances arise necessitating resuscitative measures, the Surgeon, Anesthesiologist, and employees of North Central Surgical Center will employ all necessary methods to resuscitate.

_____ **Valuables and Personal Items:** I (we) agree to assume full responsibility for items I bring such as money, jewelry, other valuables, or personal items such as dentures, eyeglasses, hearing aids, contact lenses, etc.

_____ I am of sound mind and capable of and have in fact reviewed the following information and I am hereby voluntarily initialing this Consent. The following information has been provided to and explained to me: **(1) the danger of failing to inform the medical providers of, and/or failing to remove any body piercing and/or other metal artifacts, in or on one's person, prior to the procedures discussed.**

_____ **Physician Ownership Acknowledgement (*please initial*):** North Central Surgical Center meets the definition of "physician-owned hospital" under 42 CFR 489.3. The hospital may be owned in part by your physician. You have the right to choose the provider of your health care services. Although we believe that North Central Surgical Hospital will be able to meet your needs, you have the option to use a facility other than ours. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedure(s) at such facility. If desired, your physician or staff member can provide information about alternative health care providers. If you have any questions concerning this notice, please feel free to ask your physician or an administrative representative of North Central Surgical Center.

_____ I acknowledge that one or more of the physicians providing treatment at North Central Surgical Center may have ownership interest in North Central Surgical Center. I also acknowledge that I have the right to choose the provider of my healthcare services and I have chosen North Center Surgical Center.
I acknowledge that a current listing of physician partners at North Central Surgical Center is available upon request.

I have □ **RECEIVED** -or- □ **DECLINED** this listing. (*check box*)

_____ **Patient Rights:** I have received a copy of the "Patient's Rights and Responsibilities."

DOCUMENTATION OF GOOD FAITH EFFORT

The patient identified was provided with a copy of the provider's Privacy Notice on the date. A good faith effort has been made to obtain a written acknowledgement of patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

_____ Patient refused to sign the Privacy Notice Acknowledgement.
_____ Patient was unable to sign because: _____
_____ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
_____ Other reasons: _____

_____ **Confidential / No Information Patient:** I understand that if I request to be registered as a Confidential / No Information Patient my presence will not be acknowledged other than to my caregivers and those with a need to know.

_____ **Pediatric Patients (under the age of 18 years old):** A parent/legal guardian must provide consent for medical treatment of a minor-aged patient. Any pediatric patient requiring hospitalization must be accompanied by a parent/legal guardian at all times.

_____ **Sensory or Physical Impairments**: I understand the hospital has resources to meet special needs for patients with sensory or physical impairments. I have the following special needs: _____
_____

****

_____ **MEDICARE patients only (*please initial)*:** If this is an admission, which is covered by Medicare, I have received a copy of "An Important Message from Medicare" furnished by North Central Surgical Center.

****

Non-Smoking Policy: In accordance with regulatory agency standards, North Central Surgical Center is a non-smoking facility.

Financial Agreement: The undersigned agree(s), whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligated himself/herself to pay the account of the Hospital for services in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay attorneys fees and collection expenses actually incurred. I further acknowledge that all physicians furnishing services including but not limited to radiologist, pathologist, anesthesiologist, consultants and assistants to the physician are independent contractors and not employees of the hospital. I understand that I may receive separate billing from each of these providers for services rendered.

Assignment of Insurance Benefits: I hereby authorize payment directly to North Central Surgical Center and all attending physicians of the insurance benefits specified and otherwise payable to me but not exceed the Hospital's regular charges for these services. I understand that I am financially responsible to the Hospital for charges not covered or disallowed by the assignment.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me (us), that the required blank spaces have been filled in, and that I (we) understand its contents.

_____ _____ / _____ AM/PM

PATIENT SIGNATURE OR LEGALLY RESPONSIBLE PERSON DATE TIME

_____ _____

WITNESS SIGNATURE SIGNATURE OF LANGUAGE ASSISTANCE REPRESENTATIVE (IF APPLICABLE)