

Winter Haven Ambulatory Surgical Center CONSENT FOR SURGICAL TREATMENT

| | |
|---------------------|------------|
| Patient Label _____ | Rev. 12-06 |
|---------------------|------------|

IMPORTANT: DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND UNDERSTAND ITS CONTENTS.

1. I acknowledge that I have authorized and directed my physician, Dr. _____ and/or his / her associates (from here on noted as Doctor) to perform the following operation and/or procedure (hereafter procedure) on me at Winter Haven Ambulatory Surgical Center (from here on Facility).

Procedure: _____

2. My Doctor or his designee has explained to me the diagnosis, necessity, purpose, alternatives, benefits or effects and risks of the procedure in laymen's terms.

3. I certify that, based on the information provided by my Doctor or his/her designee, I have a general understanding of the procedure to be performed, my right to refuse treatment, and that no warranty or guarantee has been made as to the result or cure.

4. I hereby authorize the above named Doctor and his/her associates or assistants to provide such additional services to me, as he, she or they may deem immediately necessary, including, but not limited to the performance of services related to the consented procedure and required for additional treatment.

5. I understand the surgical and/or diagnostic procedure to be performed on me at the Facility will be done on an outpatient basis and the Facility does not provide 24 hour patient care. I understand that I must have a responsible adult drive me home and stay with me after my procedure. If my Doctor, 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, I consent and authorize the employees of the Facility to arrange for and affect the transfer.

6. My physician has explained the possible risks and complications of this or any other procedure including but not limited to: infection, post-operative bleeding or unplanned injuries to organs, nerves or blood vessels, to include inadvertent puncture, laceration, a tearing of other internal organs and consequent hemorrhage or need for additional surgery for repair, positional injuries, failure of success of the procedure, delayed healing, scar formation, transfer to a higher level of care and cardiac or respiratory arrest and death.

7. I consent to the administration of Anesthetics as determined necessary by my physician and Anesthesiologist.

8. I agree to allow any tissue(s) removed from my body to be examined by a pathologist if my doctor deems it medically necessary or to be disposed of by the Facility in accordance with accustomed practice.

9. I understand that my physician may request the presence of a Manufacturer's Representative in the operating room during the procedure.

10. I understand that there may be a supervised healthcare student observing or assisting in the operating room during the procedure.

11. I consent to the *anonymous* taking of and publication of any photographs or videotapes during the course of the operation or procedure for medical, scientific or education purposes approved by my physician.

12. I understand and agree that all practitioners who furnish services to me at the Facility, including my Doctor, Anesthesiologist or their designee, and the like, are independent contractors of the Facility and not employees or agents of the Facility. I further understand and agree that I am under the care and supervision of my Doctor and it is the responsibility of the Facility and the nursing staff to carry out the instructions of him/her.

13. I authorize any acute care facility in which I am treated within 72 hours of my procedure to release my medical records to Winter Haven Ambulatory Service Center.

Please answer the following questions by circling YES or NO:

14. Have you read the above document? YES NO

15. Do you understand the nature, expected benefits, and risks of the procedure as well as alternative treatment options? YES NO

16. Are you satisfied that all of your questions have been answered? YES NO

17. Do you understand that there are no guarantees to procedure outcome? YES NO

18. Do you wish to have a copy of this document? YES NO

Date _____ Time _____ AM _____ PM _____

Witness _____

Physician's Signature _____

Patient's Signature _____
(or person giving consent - parent id or legal paperwork required)

Relationship to Patient _____

Patient is unable to sign because of: _____