THE OUTPATIENT SURGERY CENTER - GREENWOOD

MR #

FACILITY CONSENT FOR SURGERY

Case ID # DOS

Patient Name	DOB	Age	Sex	Surgeon

____________ reconozco que he autorizado y he dirigido a mi medico(s),

____________ y socios y/o ayudantes de su/su opcion para realizar la

operacion siguiente / el procedimiento diagnostico en mi:

- y/o tal otra operacion (ones) o procedimientos terapeuticos sobre mi, que ellos juzgan necesario o aconsejable. Reconozco que he autorizado y he dirigido a un abastecedor designado del Anesthesiology of Greenwood Grupo de Anestesia para administrar la anestesia juzgada necesario/aconsejable para el susodicho procedimiento encima. He sido informado de mi Derecho de entender el plan para mi cuidado. Ademas, reconozco que he recibido la informacion suficiente y HE firmado el Consentimiento Informado de mi medico que me explica la naturaleza y el objetivo de este procedimiento y/o anestesia, los m?todos alternativos posibles medicamente aceptados del tratamiento, riesgos sustanciales posibles y riesgos implicados, y la posibilidad de complicaciones en terminos y lengua que entiendo. Reconozco que tengo un entendimiento general de la operacion o procedimiento y ninguna garant?a o el aseguramiento ha sido hecho en cuanto a los resultados que pueden ser obtenidos.

- Consiento en otros servicios medicos, con los cuales el susodicho medico(s) llamado juzga necesario o aconsejable, incluso, pero no limitado: enfermeria, radiologia, patologia, anestesiologia y laboratorio. Consiento en servicios medicos que son necesarios para mi experiencia quirurgica total que sera proporcionada por empleados o contractees de TOSC Centro de Cirugia.

- Yo he sido proporcionado la informacion en cuanto a la propiedad de esta instalacion y aconsejado esto tengo el derecho de hacer realizar mi cirugia en cualquier otra instalacion donde mi medico tiene privilegios.

- He sido informado de mis Derechos y Responsabilidades, incluso el Derecho de archivar un agravio y el proceso; El Derecho de hacer asi y ser tratado abuso de w/o o harrassment; y los Derechos a la seguridad / intimidad de mi y mi informacion de salud.

- Autorizo al medico o el patologo para seguir Politicas y Procedimientos y su/su discrecion para averiguar la disposicion apropiada de cualquier tejido cortado, miembro u organo quitado de mi durante el procedimiento autorizado encima.

- En caso de una exposicion casual de personal o medico u otra persona en la asistencia a fluidos de cuerpo autorizo TOSC para realizar el procedimiento phlebotomy necesario para probar para determinar la presencia de enfermedad infecciosa, virus u organismo y mandar tal muestra para asignar el laboratorio donde la prueba(s) sera realizada. Adelante entiendo que toda la informacion obtenida a consecuencia de la exposicion / pruebas sera protegida segun el Acto de Responsabilidad y Portabilidad de Seguro Medico de 1996 (HIPAA).

  (Circule uno): SI NO

- Entiendo que el TOSC es un Centro de Cirugia Ambulatorio y no proporciona cuidado de 24 hora. Si mi medico y/o practicante de anestesia lo encuentran necesario o aconsejable de transferirme a un hospital, autorizo a TOSCempleados para hacer los arreglos y afectar esta transferencia. Ademas, autorizo la informacion para ser comunicada entre TOSC y hospital al cual soy transferido(a) para afectar la continuidad del cuidado. Autorizo TOSC para recibir una copia del Resumen de Descarga o equivalente del hospital dicho de acuerdo con HIPAA.

- Me han proporcionado informacion/politica en cuanto a Directivas de Avance y la aplicacion de tal en esta instalacion.

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- He designado a un representante para tomar decisiones informadas sobre mi cuidado y entender que ellos pueden hacer asi si soy incapacitado o he sido declarado incompetente por el tribunal.
- Consiento en la documentacion fotografica o de video y la publicacion de la operacion o procedimiento realizado en mi a condicion de que ninguna identidad sea revelada.

  Autorizo la posibilidad de observadores incluso, pero no limitado con estudiantes, representantes de fabricantes, y medicos de par para estar presente en la Sala de Operaciones y/o durante otras fases de mi experiencia aqui. Nombre / Asociacion de individuo para ser:

  ____________________ presente.
- Autorizo la participacion posible de estudiantes de tecnico quirurgicos o estudiantes de enfermeria en mi cuidado directo y procedimiento/cirugia. Entiendo que aquellos y todos otros estudiantes medicos y/o residentes solo pueden asistir con mi procedimiento y que mi cirujano permanecera totalmente responsable de y en el control de mi operacion y cuidado. Adelante entiendo que todos los estudiantes seran en la supervision directa de sus instructores y proporcionaran el cuidado de acuerdo con politicas y procedimientos adoptados por TOSC. Es entendido que puedo, en cualquier momento antes de la induccion de la anestesia general, solicitar que alguno y todos los estudiantes, los residentes/companeros no participen en mi cuidado directo. Nombre / Asociacion de individuo para ser presente:

  ____
- Concuerdo y autorizo esto la instalacion puede revelar la parte(s) de mi registro paciente, incluso archivos medicos, a cualquier persona, caramba la corporacion u otra entidad que puede ser obligada de todos o cualquier parte de los gastos de instalacion incluso, pero no limitada con companias de seguros, proyectos de servicio de asistencia medica, portadores de compensacion de los trabajadores, laboratorios, radiologia, anestesia y otros abastecedores de servicio.
- Soy consciente que en cualquier momento no entiendo o tengo preocupaciones en cuanto a cualquier servicio proporcionado por el personal de TOSC, mi medico o mis abastecedores de anestesia, ESTO ES MI RESPONSABILIDAD de hacer aquellas preguntas y/o concierne conocido al personal y/o medicos.
- El abajo firmante certifica que el / ella ha leido el susodicho y es el paciente que tiene la cirugia, el representante legal del paciente, o esta debidamente autorizado por el paciente como su agente general a ejecutar este acuerdo y consentir para aceptar todos los terminos.

O, SI EL PUNTO ES: ☐ MENOR ☐ INCAPACITADO(A) ☐ INCAPAZ DE FIRMAR

____

PUNTO, LA FIRMA

Describa: ____________________

____________________ ____________________

FIRMA DE FIRMA DE TESTIGO

Relacion al paciente ______ Fecha ______ Fecha ______

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☐ TENGO PREGUNTAS PARA HABLAR CON MI MEDICO / ABASTECEDOR DE ANESTESIA ANTES DE LA CIRUGIA

O : MI MEDICO HA CONTESTADO MIS PREGUNTAS SATISFACTORIAMENTE. DESEO SEGUIR CON MI PROCEDIMIENTO PREVISTO. ____________________

LA FIRMA

TESTIGO DE FIRMA

TO BE SIGNED BY ATTENDING PHYSICIAN/SURGEON/ANESTHESIA PERSONNEL PRIOR TO BEGINNING PROCEDURE IF SEPARATE COPY OF INFORMED CONSENT OBTAINED BY HIM/HER IS NOT ON MEDICAL RECORD:

I HAVE EXPLAINED THE PROCEDURE(S) AS INDICATED ON THE FACILITY CONSENT FORM TO THE PATIENT AND OR LEGAL REPRESENTATIVE INCLUDING BUT NOT LIMITED TO SPECIFIC INDICATIONS FOR THE PROCEDURE(S) ALTERNATIVES TO THE PROCEDURE(S) POSSIBLE ADVERSE OUTCOMES, RISKS OF AND COMPLICATIONS TO THE SCHEDULED PROCEDURE(S) IN COMPLIANCE WITH MY RESPONSIBILITY AS ATTENDING PHYSICIAN /ANESTHESIA PROVIDER.

Date	Time

MD Signature

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I, ________ acknowledge that I have authorized and directed my

physician(s), ________ and associates and/or assistants of his/her choice

to perform the following operation / diagnostic procedure on me:

- and/or such other operation(s) or therapeutic procedures upon me, which they deem necessary or advisable. I acknowledge that I have authorized and directed a designated provider from Anesthesiology of Greenwood to administer anesthesia deemed necessary/advisable for the above procedure above. I have been advised of my Right to understand the plan for my care. Additionally, I acknowledge that I have received sufficient information and HAVE signed Informed Consent from my physician explaining the nature and purpose of this procedure and/or anesthesia to me, possible medically accepted alternative methods of treatment, possible substantial risks and hazards involved, and the possibility of complications in terms and language that I understand. I acknowledge that I have a general understanding of the operation or procedure and no guarantee or assurance has been made as to the results that may be obtained.

- I consent to other medical services, which the above named physician(s) deems necessary or advisable, including but not limited to: nursing, radiology, pathology, anesthesiology and laboratory. I consent to medical services that are necessary for my total surgical experience that will be provided by employees or contractees of The Outpatient Surgery Center.

- I have been provided information regarding the ownership of this facility and advised that I have the right to have my surgery performed at any other facility where my physician has privileges.

- I have been advised of my Rights and Responsibilities, including the Right to file a grievance and the process; the Right to do so and be treated without abuse or harrassment; and the Rights to safety / privacy of self and my health information.

- I authorize the physician or pathologist to follow Policies and Procedures and his/her discretion to as certain the appropriate disposal of any severed tissue, member or organ removed from me during the procedure authorized above.

- In the event of an accidental exposure of personnel or physician or other person in attendance to body fluids, I authorize ASC to perform the necessary phlebotomy procedure for testing to determine the presence of infectious disease, virus or organism and to refer such sample to appropriate laboratory where test(s) will be performed. I further understand that all information obtained as a result of exposure / tests will be protected according to the Health Insurance Portability and Accountability Act of 1996.

(Circle one): YES NO

- I understand that The Outpatient Surgery Center is an Ambulatory Surgery Center and does not provide 24 hour care. If my physician and/or anesthesia practitioner find it necessary or advisable to transfer me to a hospital, I authorize The Outpatient Surgery Center employees to arrange for and affect this transfer. Additionally, I authorize information to be communicated between The Outpatient Surgery Center and hospital to which I am transferred to affect continuity of care. I authorize The Outpatient Surgery Center to receive a copy of the Discharge Summary or equivalent from said hospital in accordance with the Health Insurance Portability and Accountability Act of 1996.

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- I have been provided information / policy regarding Advance Directives and the application of such in this facility.
- I have designated a representative to make informed decisions about my care and understand that they may do so whether or not I am incapacitated or have been declared incompetent by the court.
- I consent to the photographic or video documentation and publication of the operation or procedure performed on me provided no identity is revealed.

  I authorize the possibility of observers including but not limited to students, manufacturers representatives, and peer physicians to be present in the Operating Room and/or during other phases of my experience here. Name / Association of individual to be present:

- I authorize the possible participation of surgical technician students or nursing students in my direct care and procedure / surgery. I understand that those and all other medical students and / or residents may only be assisting with my procedure and that my surgeon will remain totally responsible for and in control of my operation and care. I further understand that all students will be under the direct supervision of their instructors and will provide care in accordance with policies and procedures adopted by The Outpatient Surgery Center. It is understood that I may, at any time prior to induction of general anesthesia, request that any and all students, residents / fellows shall not participate in my direct care. Name / Association of individual to be present.

- I agree and authorize that the facility may disclose portion(s) of my patient record, including medical records, to any person, corporation or other entity that may be liable for all or any portion of the facility charges including but not limited to insurance companies, health care service plans, workers' compensation carriers, laboratories, radiology, anesthesia and other service providers.
- I am aware that at any time I do not understand or have concerns regarding any services being provided by the personnel of The Outpatient Surgery Center, my physician or my anesthesia providers, IT IS MY RESPONSIBILITY to make those questions and/or concerns known to the personnel and/or physicians.
- The undersigned certifies that he/she has read the above and is the patient having surgery, the patient's legal representative, or is duly authorized by the patient as their general agent to execute this agreement and to consent to accept all terms.

OR, IF PT IS: ☐ MINOR ☐ INCAPACITATED ☐ UNABLE TO SIGN

PATIENT SIGNATURE

Describe:

Relationship to patient Date

SIGNATURE

Date

WITNESS SIGNATURE

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☐ I HAVE QUESTIONS TO DISCUSS WITH MY PHYSICIAN / ANESTHESIA PROVIDER PRIOR TO SURGERY

Or: MY PHYSICIAN HAS ANSWERED MY QUESTIONS SATISFACTORILY. I WISH TO PROCEED WITH MY SCHEDULED PROCEDURE. ____________________

SIGNATURE WITNESS

TO BE SIGNED BY ATTENDING PHYSICIAN / SURGEON / ANESTHESIA PERSONNEL PRIOR TO BEGINNING PROCEDURE IF SEPARATE COPY OF INFORMED CONSENT OBTAINED BY HIM/HER IS NOT ON MEDICAL RECORD:

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Date	Time

PHYSICIAN / SURGEON SIGNATURE