Surgery Center of Athens
CONSENT OF DISCLOSURE AND CONSENT TO OPERATION, ADMINISTRATION OF ANESTHETICS, AND FOR DIAGNOSTIC OR THERAPEUTIC PROCEDURES

SURGERY CENTER OF ATHENS

Your physician has determined that the operation or procedure listed below may be beneficial in the diagnosis or treatment of your condition. All surgical operations and diagnostic and therapeutic procedures involve risks of unsuccessful outcomes, complications, injury or even death, from both known and unforeseen causes. No warranties or guarantees have been made as to result or cure.

Operation or procedure to be performed _____

_____

Physician/Associates/Assistant name: _____

As a patient you have the right to receive as much information as you may need in order to give informed consent or to refuse the recommended course of treatment. Except in emergencies, your physician(s) should describe in language you can understand, the nature of the ailment and the nature of the proposed treatment or procedure, the material risks or dangers involved, the alternate courses of treatment or nontreatment, including the respective risk of unfortunate consequences associated with the treatment or procedure, and the relative probability of success of the treatment or procedure. If you have questions, you are encouraged and expected to consult your physician(s) prior to giving your consent to such operation or procedure. You have the right to consent or refuse any proposed operation or procedure prior to its performance.

Having read, received and fully understanding the above information from my physician(s), I hereby authorize the following:

1. I authorize the above-named physician(s) and any of their associates or assistants to perform the above named operation or procedure and to provide such additional services as may be deemed medically reasonable and necessary, including but not limited to:
   a. Those resulting from conditions or discoveries, which, in the opinion of the professional, make a change or extension advisable;
   b. The administration and maintenance of anesthesia, as considered necessary or advisable by the professional responsible for such services;
   c. The implant of medical devices;
   d. Services involving pathology and radiology;
   e. Related follow-up care.
   f. Transfer to a hospital
2. I authorize the pathology services to use its discretion in the retention or disposal of any severed tissue or member.
3. I understand that I am required to have a companion over the age of 18 years old accompany me to the Center and be available during and after my surgery and that I will be discharged to that person's custody and must rely on him or her for my return home.
   Name of Companion: _____ Phone Number:_____ Alternate Number:_____
4. I consent to the photographing, filming, or videotaping of the treatment or procedure for diagnostic, documentation or educational use.
5. I authorize disclosure of my Social Security number to manufacturers of devices subject to the Safe Medical Device Act.
6. I authorize (family member) _____to discuss my medical/billing information with support services at the Center.
7. I acknowledge I have had the opportunity to review the Privacy Notice. It is my right to request a copy of the Privacy Notice for my own personal records.
8. I authorize the Surgery Center of Athens to obtain any follow up medical records related to the procedure I am having today for the purpose of improving healthcare operations and quality assessment.
9. I acknowledge I have had the opportunity to review the Privacy Notice. It is my right to request a copy of the Privacy Notice for my own personal records. I authorize (family member/responsible companion) to discuss my medical/billing information with support services at the Center or my physicians.
10. I understand that Advanced Directives are not honored at this facility and that in the event of an emergency or life threatening situation, advance cardiac life support procedures will be instituted in every instance and I will be transferred to a higher level of care. I do have an advanced directive _____I do NOT have advanced directive _____.

I _____ hereby give consent. _____ Relationship to Patient:_____
(Patient) or (Parent/Guardian/Conservator) Signature (Date/Time)

_____ _____
(Witness) (Date)