American Surgery Center

INFORMED CONSENT FOR SURGERY OR OTHER DIAGNOSTIC PROCEDURE

I hereby authorize Doctor _____ or any other practitioner he/she may designate to perform the following surgery or diagnostic procedure on me:

_____

1. If any unforeseen condition arises in the course of the above procedure which in his/her judgment calls for procedures in addition to or different from those now contemplated, I further request and authorize his/her or his/her designates to do whatever they deem advisable.
2. In the performance of the above surgery or diagnostic procedure, I consent to the administration of anesthesia, pre-operative therapy, and medication as indicated. I understand that anesthesia involves the possibility of loss of life or permanent disability. I certify that no warranty, guarantee or assurance of any kind has been made to me.
3. I consent to disposition by the American Surgery Center of any tissues or parts which may be removed.
4. For the purpose of advancing medical education, I consent to the admittance of qualified observers to the Operating Room, to the taking and publication of any photographs in the course of this operation and to the use of my medical records.
5. Surgical Residents and/or Fellows may be involved in the performance of your surgical procedure under the supervision of the attending surgeon.
6. I acknowledge that the comparative risks, benefits and alternatives associated with performing this procedure in an ambulatory surgery center instead of a hospital have been fully explained to me.
7. Should a blood-borne exposure occur during the procedure, I consent to the drawing of blood for HIV and Hepatitis B testing. The results of this test will be placed in my medical record and protected in accordance with applicable laws.
8. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The nature and purpose of the above procedure, possible alternative methods of treatment, the risks involved and the possibility of complications including, but not limited to, infection, hemorrhage, non-healing, or in cases of gastroenterological procedures, complications could also include perforation of the bowel, or in cases of ophthalmic procedures, blindness or loss of eye have been fully explained to me by:

_____

Surgeon's Name **Surgeon's Signature** **Date and Time**

I certify that I have read and fully understand the above INFORMED CONSENT FOR SURGERY OR OTHER DIAGNOSTIC PROCEDURE, that the explanations therein referred to were made, and that all blanks and statements requiring insertions or completions were filled in. The inapplicable paragraphs, if any, were stricken before I signed.

_____ _____

Patient's Signature Date and Time Witness' Signature Date and Time

_____ _____

Patient's Printed Name Witness' Printed Name

If the INFORMED CONSENT cannot be signed by responsible patient, have the authorized person sign below: I certify that I am legally empowered to act for the above patient, and do consent to the procedure as stated above.

_____ _____

Authorized Individual's Signature Date and Time Witness' Signature Date and Time

_____ _____

Authorized Individual's Printed Name Witness' Printed Name