APOLLO SURGERY CENTER

Patient Name:
Surgeon:
Date of Service:
Medical Record:
Date of Birth:
Age:

PATIENT CONSENT TO PROCEDURE

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:

❒ **Esophagogastroduodenoscopy with possible biopsy, polypectomy, dilation of stricture, tattooing, bleeding control, and/or therapeutics**

❒ **Flexible Sigmoidoscopy with possible biopsy, polypectomy, dilation of stricture, tattooing, bleeding control, and/or therapeutics**

❒ **Colonoscopy with possible Ileoscopy, biopsy, polypectomy, dilation of stricture, tattooing, bleeding control, and/or therapeutics**

❒ _____

_____

Your treating physician may be an independent contractor and therefore is not an employee of Apollo Surgery Center ("Center"). Independent contractor physicians also provide anesthesia services at the Center.

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 healthcare provider should describe in language you can understand, the nature of the ailment and the or nature of the proposed treatment or procedure, the material risks or dangers involved, the alternate courses of treatment 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 healthcare provider 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 and fully understanding the above, and having received and fully understanding the above information from my physician(s) and/or podiatrist(s), I hereby authorize the following:

1. I authorize the above-named healthcare provider and any of their associates or assistants, including residents within their licensed scope of their practice, to perform the above-named 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 make a change or extension advisable;
   b. The administration of anesthesia by a healthcare professional including local anesthesia by the surgeon;
   c. The implantation of medical devices
   d. Services involving pathology and radiology;
   e. Transfer to a hospital and issuance of the hospital's discharge summary to the Center.
   f. Post-operative testing of my blood in the event of a sharps injury during my stay involving my blood.
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, if given other than local anesthetic, I am required to have a responsible adult 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.
4. I consent to the photographing, filming, or videotaping of the treatment or procedure for diagnostic, documentation or educational use. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the Center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carrier(s) as well as to those individuals the Governing Body may deem appropriate to review the medical record for purposes of medical quality assurance/improvement and peer review.
5. I authorize disclosure of my Social Security number to device manufacturers subject to the Safe Medical Device Act.
6. I have received verbal and written notification of the Center's patient rights, advance directives and understand that this facility respects human life and will not follow any advance directives that may be in place.
7. Your treating physician may have an ownership interest in the Center and may gain financially by performing the procedure at the Center. You, the patient, have the right to choose where your procedure is performed. By signing this consent, you are agreeing to have the procedure performed at Apollo Surgery Center.

I certify that I have read and fully understand the above consent statement, that the explanations herein referred to are understood by me, that all my questions have been answered, that all blanks or statements requiring insertion or completion were filled in prior to the time of my signature, and that this consent is given freely, voluntarily and without reservation. I understand that I have the right to refuse any medical and surgical procedures and treatment.

X _____ _____

Signature of Patient/Date — Person Legally Authorized To Consent for the Patient

_____ _____

Witness/Date — Relationship, If Other Than Patient Signing

_____

Attending Physician/Surgeon