SPECIALTY SURGERY CENTER
SOUTH COAST

Patient Name:
Surgeon:
Date of Service:
Social Security #:
Date of Birth:
Medical Record #:

# PATIENT CONSENT TO PROCEDURE

Your physician, Dr. _____, 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_____

_____

You have the right to receive as much information as you may need in order to provide informed consent or to refuse the recommended course of treatment. By signing below, you, the patient or patient representative, agree that informed consent has been provided by your healthcare provider in language you can understand. Informed consent includes a discussion between the patient or patient representative and healthcare provider of the nature of the ailment, the nature of the proposed treatment or procedure, the material risks or dangers involved including potential complications, relative probability of success of the treatment or procedure, the benefits of the proposed procedure, the alternate courses of treatment, and the and discussion of the risks and potential results of NOT undergoing the proposed procedure(s). 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 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 and maintenance of anesthesia as directed by a healthcare professional;
   c. The implant of medical devices
   d. Services involving pathology and radiology;
   e. 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.
   Exceptions: ☐ None _____
3. I understand that, if given other than local anesthetic, I am required to have a companion 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 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 this Center.
8. Your treating physician or podiatrist is an independent contractor and is ***not*** an employee of South Coast Specialty Surgery Center ("Center"). Anesthesia services at the Center are also provided by independent contractor physicians

*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