EAST ALABAMA AMBULATORY SURGERY CENTER

SURGICAL CONSENT

I, _____acknowledge that I have authorized and directed my physician, _____and associates or assistants of his choice to perform the following operation or diagnostic procedure on me:

_____

and/or such other operation(s) or therapeutic procedures upon me, which they deem necessary or advisable. Additionally, I acknowledge that I have received an Informed Consent from my physician explaining the nature and purpose of this procedure to me, possible medically accepted alternative methods of treatment, the substantial risks and hazards involved, and the possibility of complications. I acknowledge that I have a general understanding of the operation or procedure and no guarantee of assurance has been made as to the results that may be obtained.

I consent to other medical services, which the above-named physician deems necessary or advisable, including but not limited to anesthesia, nursing, radiology, pathology, and laboratory. I consent to medical services that are necessary for my total surgical experience that will be provided by employees of EAST ALABAMA AMBULATORY SURGERY CENTER.

I authorize the physician or pathologist to use his/her discretion in the disposal of any severed tissue, member or organ removed from me during the procedure above.

I understand that the EAST ALABAMA AMBULATORY 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 EAST ALABAMA AMBULATORY SURGERY CENTER employees to arrange for and affect this transfer. Additionally, I authorize for information to be communicated to the transferring Center for continuity of care as well as EAASC receiving a copy of the Discharge Summary or Summary Notes from the transferring Center in accordance with the Health Insurance Portability and Accountability Act of 1996.

I consent to the photographic or video documentation and publication of the operation or procedure performed on me provided no identity is revealed.

I CERTIFY THAT I HAVE REMOVED ALL DENTURES, PROSTHESES, GLASSES AND JEWELRY (TO INCLUDE BODY PIERCINGS) OR ASSUME RESPONSIBILITY FOR ANY LOSS OR DAMAGE THAT RESULTS FROM MY FAILURE TO DO SO.

I agree and authorize that EAASC may disclose portion(s) of the patient's record, including his/her medical records, to any person, corporation or other entity that may be liable for all or any portion of EAASC charges. This includes, but is not limited to, insurance companies, health care service plans, worker's compensation carriers, laboratories and radiology providers.

I authorize one or more 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 surgical admission.

I am aware that at any time I do not understand or have concerns regarding any services being provided by the personnel of EAST ALABAMA AMBULATORY 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 its terms.