DISCLOSURE AND CONSENT TO MEDICAL AND SURGICAL PROCEDURES

To Our Patient:

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. **VOLUNTARY REQUEST FOR TREATMENT:** I (we) voluntarily request Dr. as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition, which has been explained to me (us) as:

2. **PLANNED PROCEDURE(S):** I (we) understand that the following surgical, medical, and/or diagnostic procedure(s) are planned for me and I (we) voluntarily consent to and authorize these procedure(s):

3. **DISCOVERY OF OTHER CONDITIONS**: I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgment.

4. **BLOOD/BLOOD PRODUCTS:** PATIENT INITIALS

I (we) ☐ (Do) ☐ (Do Not) consent to the use of blood and/or blood products as deemed necessary.

I (we) understand the risks and hazards associated with the use of blood and blood products are: fever, transfusion reaction, which may include kidney failure or anemia, heart failure, hepatitis, AIDS (Acquired Immune Deficiency Syndrome) and other infections.

5. **RISKS OF TREATMENT:** I (we) understand that no warranty or guarantee has been made to me as to results or cure.

Just as there are risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedure(s) planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:

6. **OPPORTUNITY TO ASK QUESTIONS:** I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedure(s) to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

7. **CERTIFICATION – UNDERSTANDING OF CONSENT FORM:** I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

Patient Signature | Date | Witness | Time

If the patient is a minor or unable to sign, complete the following:

☐ Patient is a Minor. ☐ Patient is unable to sign because _____

Signing on behalf of patient: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other _____

Parent/Guardian/POA Signature | Parent/Guardian/POA Printed Name | Date

PATIENT IDENTIFICATION

St David's | North Austin Surgery Center
12201 Renfert Way, Suite 120 • Austin, Texas 78758
NAS-068 (04/13) Tel. 512.832.9088 Fax. 512.833.6137

FACILITY DISCLOSURE AND CONSENT

1. **RESPONSIBLE RIDE HOME:** I (we) understand that I am scheduled to go home after my surgery and I must have a responsible adult drive me home and stay with me as advised by my physician.

   I (we) understand the surgery is intended to be performed on an outpatient basis. I consent to my transfer to a hospital or other facility should my physician(s) deem it advisable or necessary.

   I (we) understand the Surgery center is not responsible or liable for the loss of or damage to any article of value that I have brought to this facility.

2. **TISSUE/COMMUNICABLE DISEASES:** I authorize the surgery center to dispose of any specimen or tissue taken from my body during this operation or procedure. In the event any tissue is deemed potentially pathological it will be sent to pathology.

   I (we) understand that Texas law provides and I (we) agree, that if any healthcare worker is exposed to my blood or other bodily fluid, to allow North Austin Surgery center to perform tests on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, hepatitis and human immunodeficiency virus (which is the causative agent of AIDS). I (we) understand that such testing is necessary to protect those who will be caring for me while I am a patient of the Surgery center. I (we) understand that the results of such tests do not become a part of my medical record.

3. **MEDICAL STAFF AFFILIATION:** I (we) understand that each patient is admitted under the care of the patient's attending physician. I (we) understand that although all physicians practicing at North Austin Surgery Center are members of North Austin Surgery Center medical staff, they are not agents or employees of the facility and are not authorized to make representations on behalf of the facility. Specifically, I (we) understand radiologists, pathologists, anesthesiologists, and all other physicians, are independent contractors and are not agents or employees of North Austin Surgery Center. I (we) further understand and agree that North Austin Surgery Center is not liable or responsible for the care and treatment rendered to the patient by the physician members of the Surgery center's medical staff.

4. **PHOTOGRAPHING OR VIDEOTAPING:** For the purpose of advancing medical education, I authorize my doctor and/or such associates as he/she may select to photograph or video tape the operation(s) or procedure(s) to be performed including appropriate portions of my body, and the inclusion of such pictures in my medical record. I understand that the photographs/ video will be used only for medical and educational purposes and will not be released for publication in any other context without my written permission.

   I (we) consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the center's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

5. **PROTECTED HEALTH INFORMATION:** Your physician may provide to you, or upon your request, you may receive your protected health information (PHI) in an unencrypted format. This means that there is some level of risk that a third party could see your PHI without your consent. Because you have requested it in an unencrypted format, North Austin Surgery Center is not responsible for unauthorized access to the PHI contained in this format.

6. **RESUSCITATIVE MEASURES:** It is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an Acute Care Hospital for further evaluation. At the Acute Care Hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive or Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney. Please provide us a copy of that document so that it may be made a part of your medical record.

PATIENT SIGNATURE _____ DATE _____

If the patient is a minor or unable to sign, complete the following: ☐ Patient is a minor. ☐ Patient is unable to sign because _____

Signing on behalf of patient: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other _____

Parent/Guardian/PDA Signature _____ Relationship to Patient _____ Date _____

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