EVANS SURGERY CENTER
Consent For Anesthesia Services

I acknowledge that my doctor has explained to me that I will have an operation or procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments, told me about expected outcomes and what would happen if my condition remains untreated. I understand that anesthesia services are requested or needed so that my doctor can perform the operation or procedure. I further understand that the administration of such anesthetic or anesthetics deemed suitable by my surgeon will be provided by either Physician Anesthesiologists or Certified Registered Nurse Anesthetists.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks that have been identified below may apply to a specific type of anesthetic. I understand that the type of anesthetic checked below will be used for my surgery or procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of surgery or procedure my doctor is to do, the surgeon's preference and my own desires. It has been explained that sometimes an anesthetic technique which involves the use of local anesthetics, with or without sedation, will not succeed completely and therefore another technique may have to be used including general anesthesia.

The following anesthetic technique has been selected for my procedure:

_____ **GENERAL ANESTHESIA** Total unconscious state, possible placement of tube in windpipe. Risks include mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia. Injury to blood vessels, aspiration and pneumonia.

_____ **SPINAL OR EPIDURAL** Temporary loss of feeling and/or movement to the lower part of the body.Risks include headache,backache,buzzing or ringing in the ears, convulsions,infection, persistant weakness, numbness, residual pain, injury to blood vessels and "total spinal".

_____ **REGIONAL ANESTHESIA** Temporary loss of feeling and/or movement in a specific limb or area. This type of anesthetic includes major nerve blocks (such as axillary blocks) and I.V. regional anesthesia. Risks include infection, convulsions, weakness, persistent numbness, residual pain and injury to blood vessels.

_____ **LOCAL WITH SEDATION** Medications (sedatives, narcotics, etc.) are given in conjunction with local anesthetics to produce a relaxed, pain-free, semi-conscious state. Risks include unconscious state, depressed breathing, anxiety, and/or discomfort and injury to blood vessels.

_____ **OTHER** (specify)

I hereby consent to the anesthesia service checked above and authorize that it be administered by Anesthesia Consultants of Augusta,LLC.,all of whom are credentialed to provide anesthesia services at this facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them.

I further acknowledge that I have in my possession the written pre/post operative anesthesia instructions which I have read, fully understand, and will follow accordingly. I further certify that for my own safety, I will have a responsible adult take me home after my surgery and stay with me overnight.

_____ _____

Patient or Substitute Signature (state relationship if substitute) Date Time

_____ _____

Witness Signature Anesthesia Provider Executing Consent

Patient Label

EVANS SURGERY CENTER

Informed Consent to Treat and Disclose Information

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 performed so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby consent to the performance of operations and procedures in addition to or different from those now planned whether or not arising from presently foreseen conditions, which the doctor named below may consider necessary or advisable during the operation or procedure.

I 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. I understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I voluntarily consent and authorize those procedures:

_____

_____

_____

_____

(Initials)

____ I consent to the transfusion of blood, blood components as deemed necessary.

____ I understand that any tissues or body parts removed during the course of my treatment will be disposed of within the discretion of the physician, Surgery Center, or other healthcare provider in accordance with Georgia laws.

____ I authorize my doctor and/or such assistants as he/she may select to photograph or video the procedure for documentation & educational purposes. I understand this will not be released for publication in any other context without my expressed written permission.

____ For the purpose of advancing medical education, I consent to the admittance of students or other observers to the room in which the procedure is performed.

____ I hereby consent to the withdrawal of a blood sample from my body in the event that a Surgery Center employee,physician, or any other healthcare provider, has had an accidental needle puncture or mucous membrane exposure to my blood or body fluid. I also understand that if an accidental contact does occur, that any blood drawn will be tested and handled in a manner that protects my privacy and identity. No results of any tests done on my blood will be released or shown to any unauthorized person without my written authorization. No negative test result will be placed in my medical record.

____ I 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.

Patient Label

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_____ I understand that it may be necessary to have technical support personnel present during the performance of my procedure(s).

_____ I understand the Surgery Center is not responsible or liable for the loss of or damage to any article of value that I brought to the Center.

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

_____ The nature, purpose, and possible complications of the procedure and medical services described above; risks and benefits reasonably expected; and the alternative methods of treatment have been explained to me by the physician; and I understand the explanation I have received.

_____ I have received a copy of the Surgery Center's Notice of Privacy Practices and consent to the uses and disclosures of my protected health information as outlined in the Notice. I specifically consent to the disclosure of my protected health information to any person or entity that may be responsible for all or any portion of the charges for my care incurred at the Surgery Center.

_____ Because of the possible adverse effects of some medications on an unborn fetus, it is important to know if the patient is pregnant. Therefore, I certify that to the best of my knowledge I am not (the patient is not) pregnant.

_____ I acknowledge that I have received verbal and written notice of Patient Rights/ Responsibilities, Advanced Directives, Grievance Process, Statement of Patient Visitation Rights and a list of Physician Ownership prior to my procedure.
☐ Your physician does not have a financial interest/ownership in the surgery center.
☐ Your physician does have a financial interest/ownership in the surgery center.

_____ Consent to Telephone Calls for Financial Communications
With regards to services rendered and/or my related financial obligations, I expressly agree and consent that DHSC DBA Evans Surgery Center and any associated affiliate / vendor providing quality improvement, customer service, billing or collection services may contact me by any method of contact (such as a telephone call utilizing an automated dialing device, dialing services, prerecorded message or texting) to any telephonic number that I have provided to the surgery center, or has been obtained by the surgery center or any of its associated affiliates/ vendors or at a number forwarded or transferred from that number, including mobile telephone numbers.

Consent to Medication Not Yet FDA Approved and/or Medication Prepared/Repackaged by Outsourcing or Compounding Pharmacy. As part of the services provided, you may be treated with a medication that has not received FDA approval. You may also receive a medication that has been prepared or repackaged by an outsourcing facility or compounding pharmacy. Certain medications, for which there are no alternatives or which your physician recommends, may be necessary for potentially life-saving treatment.

Patient Label

Continued on Page 4

In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated in the Surgery Center's price list (known as the "Charge Master") effective on the date of service, which rates are hereby expressly incorporated by reference as the price term of this Agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or the charge is listed as zero. In the event that the Surgery Center has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to herein, the undersigned agrees to the attorney's fees and collection expenses incurred by the Surgery Center.

An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Surgery Center. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

We may use or disclose information about you to bill or receive payment for medical treatment or services provided to you. These disclosures include releasing information;

(1) to your health plan to obtain prior approval or to determine whether your plan will cover the treatment or services; or
(2) to individuals or entities involved in collecting amounts owed to us.

Some or all of the health care professionals performing services in the Ambulatory Surgery Center are independent contractors and are not Surgery Center agents or employees. Independent contractors are responsible for their own actions and the Surgery Center shall not be liable for the acts or omissions of any such independent contractors.

(if the patient is a minor or unable to sign, complete the following)

☐ Patient is a minor
☐ Patient is unable to sign because _____

_____

_____

Patient Parent Legally Designated Representative

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name _____

Name _____

Name _____

Signature of patient _____

Date Witness Time

Patient Label

EVANS SURGERY CENTER

CONSENT TO ROUTINE PROCEDURES & TREATMENTS

Important: Do not sign this form without reading and understanding its consents. Mark out and initial any Procedure and/or section of this form for which consent is not granted.

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals ("Healthcare Professional's").

While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

If I have any questions, or concerns regarding these Procedures, I will ask my physician to provide me with additional information. The Procedures may include the following:

(1) Needle Sticks, such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures, include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

(2) Physical tests, assessments and treatments such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, respiratory therapy, physical therapy, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) Administration of Medications whether orally, rectally, topically or through my eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage, or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) Drawing Blood, Bodily Fluids or Tissue Samples such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

(5) Insertion of Internal Tubes such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal or treatment, no practical alternatives exist.

Patient Label

I understand that:

> The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Procedures:

> The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; and

> **Some or all of the healthcare professionals performing services in this Ambulatory Surgery Center are independent contractors and are not Surgery Center agents or employees. Independent contractors are responsible for their own actions and the Surgery Center shall not be liable for the acts or omissions of any such independent contractors.**

> **Physicians may ask me to sign additional required Informed Consent documents for specific procedures and tests.**

By Signing this form:

> I consent to Healthcare Professionals performing Procedures as they deem reasonably necessary or desirable in the exercise of their professional judgement, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained**; and

> I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.

Signature of Patient:_____
(or other person authorized to sign) (Witness)

Printed Name of Patient:_____

Date Signed:_____ Time Signed: _____

Reason Patient Unable to Sign (if applicable):_____

Patient Label

AMBULATORY SURGERY CENTER PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not A Revocation Of Advance Directives Or Medical Powers Of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Surgery Center respects and upholds those rights.

However, unlike in an Acute Care Hospital setting, the Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risk, your expected recovery and care after your surgery.

Therefore, it is our policy, as a matter of conscience and as permitted by Georgia state statute code Chapter 32 of Title 31 regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event or unexpected deterioration 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.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

Please check the appropriate box in answer to these questions. Have you executed an Advance Health Care Directive, a Living Will, a Power of Attorney that authorizes someone to make health care decisions for you?

- ☐ Yes I have an Advance Directive, Living Will or Health Care Power of Attorney
- ☐ No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.*
- ☐ I would like to have information on Advance Directives.

If you checked the first box "Yes" to the question above, please provide us a copy of that document so that it may be made a part of your medical record.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of that information.

By:_____ _____

(Patient's Signature) Date

If consent to the procedure is provided by anyone other than the patient, this form must be signed by the person providing the consent or authorization.

I acknowledge that I have read and understand its contents and agree to the policy as described.

By:_____ _____

(Signature) Date

_____

(Print Name)

Relationship to Patient

- ☐ PARENT
- ☐ COURT APPOINTED GUARDIAN
- ☐ ATTORNEY IN FACT
- ☐ HEALTH CARE SURROGATE
- ☐ OTHER _____

If the patient answered YES to having an Advance Directive, Living Will, or Healthcare Power of Attorney:

- ☐ A copy was provided and placed in the patient's medical record
- ☐ A copy was not provided
- ☐ *Not applicable (If patient answered NO)

Center Representative: _____

Patient Label