roxbury
SURGERY CENTER

CONSENT OF DISCLOSURE AND CONSENT TO OPERATION ADMINISTRATION OF ANESTHETICS, AND FOR DIAGNOSTIC OR THERAPEUTIC PROCEDURE

NAME OF PATIENT: _____ DATE: _____

NAME OF PHYSICIAN: _____ TIME: _____

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, 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: _____.

Your treating physician is an independent contractor and is not an employee of the ROXBURY SURGERY CENTER ("Center"). Any professional radiology services at the Center will be provided by independent contractor physicians. Professional anesthesia services at the Center are provided by independent contractor physicians.

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 physician(s), should describe in language you can understand, the nature of the ailment and the nature of the proposed treatment or procedure, the material risks or dangers involved, the alternate courses of treatment or 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 physician(s), before giving your consent to such operation or procedure. You have the right to consent or refuse any proposed operation or procedure before its performance.

Having read and fully understanding the above, and having received and fully understanding the above information from my physician(s), I hereby authorize the following:

1. I authorize the above-named physician(s) and any of their associates or assistants to perform the above named operation or 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, in the opinion of the professional, make a change or extension advisable;
   b. The administration and maintenance of anesthesia, as considered necessary or advisable by the professional responsible for such services;
   c. The implant of medical devices and intraoccular lenses;
   d. Services involving pathology and radiology;
   Related follow-up care. 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: _____
3. I understand that I am required to have a companion accompany me to the Center and be 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 observation photographing, filming, or videotaping of the treatment or procedure for diagnostic, documentation or educational use.
5. I authorize disclosure of my Social Security number to manufacturers of devices subject to the Safe Medical Device Act.

FINANCIAL AGREEMENT: Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms, should my insurance company deny payment. I shall also be responsible for any deductible or co-pay owed at the time of service. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys' fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law. 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.

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.

_____	_____	_____	_____
Witness	Date	Patient/Parent/Guardian/Conservator	Date

(In the event that the patient is a minor, unconscious, or is otherwise not competent to give consent due to physical or mental condition, complete the following:)

I,_____ the_____of ,_____ hereby give consent on his/her behalf

(Name) (Relationship to Patient) (Patient)

_____	_____	_____	_____
Witness	Date	Patient/Parent/Guardian/Conservator	Date