Piedmont Surgery Center
1800 Howell Mill Road
Suite 250
Atlanta, Georgia 30318

Patient Label

FACILITY CONSENT FOR SURGERY

FACILITY OWNED PARTIALY / FULLY BY A GROUP OF PHYSICIANS. NAMES ARE AVAILABLE FROM RECEPTIONIST AND ON LOBBY WALL.

I, _____acknowledge that I have authorized and directed my physician(s), _____ and associates and/or assistants of his/her choice to perform the following operation/diagnostic procedure on me:

and/or such other operation(s) or therapeutic procedures upon me, which they deem necessary or advisable. I acknowledge that I have authorized and directed a designated provider from Piedmont Anesthesia to administer anesthesia deemed necessary/advisable for the above procedure above. Additionally, I acknowledge that I have received sufficient information and HAVE signed Informed Consent from my physician explaining the nature and purpose of this procedure and/or anesthesia to me, possible medically accepted alternative methods of treatment, possible substantial risks and hazards involved, and the possibility of complications in terms and language that I understand. I acknowledge that I have a general understanding of the operation or procedure and no guarantee or assurance has been made as to the results that may be obtained. _____ initials (if not, see box below)

I consent to other medical services, which the above named physician(s) deems necessary or advisable, including but not limited to: nursing, radiology, pathology, anesthesiology and laboratory. I consent to medical services that are necessary for my total surgical experience that will be provided by employees of the Piedmont Surgery Center. _____initials

I have been provided information in writing, prior to today, and verbally regarding the ownership of this facility and have been advised that I have the right to have my surgery performed at any other facility where my physician has privileges. I have been offered information regarding Advance Directives prior to today. _____ initials

I have been advised of my Rights and Responsibilities, been given a copy with verbal reinforcement, been given a chance to ask questions and I acknowledge receipt and understanding of such prior to today. _____ initials

I authorize the physician or pathologist to follow Policies and Procedures and his/her discretion to ascertain the appropriate disposal of any severed tissue, member or organ removed from me during the procedure authorized above. _____ initials

In the event of an accidental exposure of personnel or physician or other person in attendance to body fluids I authorize Piedmont Surgery Center to perform the necessary phlebotomy procedure for testing to determine the presence of infectious disease, virus or organism and to refer such sample to appropriate laboratory where test(s) will be performed. I further understand that all information obtained as a result of exposure / tests will be protected according to the Health Insurance Portability and Accountability Act of 1996. ☐ YES, I AGREE ☐ NO, I DO NOT AGREE **_____ initials**

I understand that the Piedmont 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 Piedmont Surgery Center employees to arrange for and affect this transfer. Additionally, I authorize information to be communicated between Piedmont Surgery Center and hospital to which I am transferred to affect continuity of care. I authorize Piedmont Surgery Center to receive a copy of the Discharge Summary or equivalent from said hospital in accordance with the Health Insurance Portability and Accountability Act of 1996. _____ initials

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

I authorize the possibility of 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 admission. _____ initials

I authorize the possible participation of surgical technician students or nursing students in my direct care and procedure/surgery. I understand that those and all other medical students and/or residents may only be assisting with my procedure and that my surgeon will remain totally responsible for and in control of my operation and care. I further understand that all students will be under the direct supervision of their instructors and will provide care in accordance with policies and procedures adopted by Piedmont Surgery Center. It is understood that I may, at any time prior to induction of general anesthesia, request that any and all students, residents/fellows shall not participate in my direct care. _____ initials

I agree and authorize that the facility may disclose portion(s) of my patient record, including medical records, to any person, corporation or other entity that may be liable for all or any portion of the facility charges including but not limited to insurance companies, health care service plans, workers' compensation carriers, laboratories, radiology, anesthesia and other service providers. _____ initials

I am aware that at any time I do not understand or have concerns regarding any services being provided by the personnel of Piedmont 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. _____ initials

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 all terms.

_____ _____ _____AM/PM
PT. SIGNATURE **DATE** **TIME**

OR, IF PT IS: ☐ MINOR ☐ UNABLE TO SIGN ☐ INCAPACITATED DESCRIBE: _____

_____ _____ _____AM/PM
SIGNATURE: ☐ PARENT ☐ LEGAL GUARDIAN ☐ POWER OF ATTY. ☐ PT. REP. FOR HIPAA **DATE** **TIME**

_____ _____ _____AM/PM
WITNESS SIGNATURE **DATE** **TIME**

►_____I HAVE QUESTIONS TO DISCUSS WITH MY PHYSICIAN / ANESTHESIA PROVIDER PRIOR TO SURGERY◄
MY PHYSICIAN HAS ANSWERED MY QUESTIONS SATISFACTORILY. I WISH TO PROCEED WITH MY SCHEDULED PROCEDURE.

_____
_____
SIGNATURE **WITNESS**

TO BE SIGNED BY ATTENDING PHYSICIAN/SURGEON/ANESTHESIA PERSONNEL PRIOR TO BEINNING PROCEDURE IF SEPARATE COPY OF INFORMED CONSENT OBTAINED BY HIM/HER IS NOT ON MEDICAL RECORD:

I HAVE EXPLAINED THE PROCEDURE(S) AS INDICATED ON THE FACILITY CONSENT FORM TO THE PATIENT AND OR LEGAL REPRESENTATIVE INCLUDING BUT NOT LIMITED TO SPECIFIC INDICATIONS FOR THE PROCEDURE(S) ALTERNATIVES TO THE PROCEDURE(S) POSSIBLE ADVERSE OUTCOMES, RISKS OF AND COMPLICATIONS TO THE SCHEDULED PROCEDURE(S) IN COMPLIANCE WITH MY RESPONSIBILITY AS ATTENDING PHYSICIAN /ANESTHESIA PROVIDER.