

# CONSENT FORM

## CONSENT FOR TREATMENT

1. The facility maintains personnel and equipment to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physician, surgeons and practitioners are not agents, servants, or employees of the facility, but independent contractors and, therefore, are the patient's agents or servants. The facility provides nursing and support services and equipment; the facility does not provide medical physician care.
2. The procedure(s) listed to be performed and the advantages and disadvantages, risks, and possible complications as well as the alternatives have been explained to me by my physician. The doctor has satisfactorily answered my questions.
3. My consent is give with the understanding that any operation or procedure involves risks and hazards. The more common risks include: infection, bleeding with the need for a blood transfusion, nerve injury, blood clots, heart attack, stroke, allergic reaction, damage to teeth or bridgework and pneumonia. These risks can be serious and possibly fatal.
4. I authorize the pathologist or physician to use his or her discretion in disposing of any member, organ, implant, prosthetic or other tissue removed from my person during the operation(s) or procedure(s).
5. The facility may participate in residency or other training programs for physicians, allied health professionals and other providers of services. All care rendered by individuals in training will be supervised and reviewed, as appropriate, by appropriate personnel. I hereby consent to care and treatment from individuals in training and to the review of any patient record by the same.
6. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV and Hepatitis.
7. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participant in the actual procedure.
8. I consent to the use of videotaping or photography that may be used for scientific or teaching purposes, and to the review of my medical record for bona fide medical healthcare research providing my name or identity is not revealed.
9. I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility.
10. I understand that if I am pregnant or if there is any possibility I may be pregnant, I must inform the facility immediately since the scheduled procedure could cause harm to my child or to myself.

11. I understand that in the rare event that hospitalization is required during or immediately after surgery, my physician will arrange for my transfer to a local hospital.
12. My signature below constitutes my acknowledgement that (1) I have read or have had read to me the foregoing, and I agree to it; (2) the procedure(s) has been adequately explained by my physicians; (3) I authorize and consent to the performance of the procedure(s) and additional procedure(s) deemed advisable by my physician in his or her professional judgment; (4) I authorize and consent to the administration of anesthesia for the said procedure(s).
13. If I am not the patient, I represent that I have the authority of the patient who, because of age or other legal disability, is unable to consent to the matters above. I have full right to consent to the matters above, and I consent to same (b) I hereby indemnify and hold harmless the facility, its employees, agents, medical staff, partners, and affiliates from any cost or liability out of my lack of adequate authority to give this consent.

## CONSENT TO PAYMENT AND COLLECTION

14. I hereby assign and grant to NPSC all rights and interests to which I may be entitled under any insurance policy, Medicare, or any other fund or third party payment plan responsible for payment of my benefits. I authorize payment of any such benefits directly to NPSC.
15. I understand that I will be billed separately for services provided by my physicians, anesthesiologists, radiologists, and other physicians providing medical services at NPSC.
16. I acknowledge that if a check in payment of the insurance benefits is sent by my insurance company to me, either in error or because of insurance company policy, I agree to endorse and deliver the check to North Point Surgery Center. I understand that by virtue of the assignment described in the Consent, any funds I receive belong to NPSC and that it is UNLAWFUL to use or apply funds in any other way. In the event the insurance company check is more than the outstanding NPSC bill, satisfactory arrangements can be made between NPSC and the undersigned.
17. **I agree that I am responsible for payment of NPSC's established charges currently in effect to the extent that said charges are not covered, allowed or paid by my insurance company, Medicare, or any other funds or third party payer.** I understand I will not be responsible for the payment of any of these charges that NPSC is restricted from collecting by law or agreement.
18. In the event the account remains unpaid, NPSC may turn the account over to a collection agency or attorney for collections; and if NPSC sues me to collect any amounts owed, I agree to pay NPSC's actual collection costs, including reasonable attorney's fee as allowed by the laws of the Commonwealth of Pennsylvania.
19. I authorize NPSC to file grievances with my insurance company, third party payers, case utilization and managed care review organizations which may be necessary to challenge denials of authorization or payment for a healthcare service.



# ADVANCE DIRECTIVE FOR HEALTH CARE STATUTORY FORM

## DECLARATION

I, \_\_\_\_\_, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment. In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I do \_\_\_\_\_ do not \_\_\_\_\_ want cardiac resuscitation

I do \_\_\_\_\_ do not \_\_\_\_\_ want mechanical respiration

I do \_\_\_\_\_ do not \_\_\_\_\_ want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water)

I do \_\_\_\_\_ do not \_\_\_\_\_ want blood or blood products

I do \_\_\_\_\_ do not \_\_\_\_\_ want any form of surgery or invasive diagnostic tests

I do \_\_\_\_\_ do not \_\_\_\_\_ want kidney dialysis

I do \_\_\_\_\_ do not \_\_\_\_\_ want antibiotics

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may \_\_\_\_\_. The declarant, or the person on behalf of and at the direction of the declarant, knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness: \_\_\_\_\_

## OTHER INSTRUCTIONS:

I do \_\_\_\_\_ do not \_\_\_\_\_ want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

Name and address of surrogate (if applicable):

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Name and address of substitute surrogate (if surrogate designated above is unable to serve):

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I do \_\_\_\_\_ do not \_\_\_\_\_ want to make an anatomical gift of all or part of my body, Subject to the following limitations, if any:

I made this declaration on the \_\_\_\_\_ day of \_\_\_\_\_ (month, year)

Declarant: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

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Witness: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

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