SURGECENTER OF LOUISVILLE *an affiliate of* **SCA**

4005 Dupont Circle LOUISVILLE, KY 40207 502-897-7401

ID / Visit: /

DATE	TIME IN	LAST NAME	FIRST NAME	M.I.	DEPOSIT	ATTACHMENT	C.I.

M/F	DOB	AGE	MSW	HOME PHONE	RIDE/PHONE	NEED TO CALL	WILL BE HERE

ADDRESS STREET	CITY	COUNTY	STATE	ZIP

PRIOR ADMIT	SSN	DRIVER LICENSE	OCCUPATION	WORK PHONE

RESPONSIBLE PARTY NAME AND ADDRESS IF DIFFERENT FROM ABOVE	Email

RELATION TO RESPONSIBLE PARTY	RESPONSIBLE PARTY SSN	RESPONSIBLE PARTY EMPLOYER	RESPONSIBLE PARTY PHONE

PRIMARY INS. CO. NAME/NAME OF INSURED			SECONDARY INS. CO. NAME/NAME OF INSURED		
I.D. .#/SSN	GROUP#	AUTHORIZATION	I.D. .#/SSN	GROUP#	AUTHORIZATION
INSURED'S EMPLOYER AND PHONE			INSURED'S EMPLOYER AND PHONE		

SURGEON	DOI	CLAIM#	ATTENTION

DIAGNOSIS

PROPOSED SURGERY

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I hereby assign to and authorize payment directly to the facility named above (the "facility") of all benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility. I further assign and authorize direct payment to physicians providing services at the facility of all insurance benefits payable under the terms of any insurance policy for the services and medical treatment rendered by physicians who are authorized to bill.

A photostatic copy of this agreement shall be considered effective and valid as the original.

I irrevocably agree that the facility may disclose, to the extent allowed by the law, my medical and financial record to (a) any affiliate of the facility, specifically including Surgical Care Affiliates and its employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, or any person or entity responsible for all or part of the facility's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Centers for Medicare and Medicaid Services, any other governmental or accrediting agency, or their agents and employees.

Information Privacy: This surgery center will use and disclose your personal information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

All facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payor. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the facility files for reimbursement from my insurer or other payor as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amounts when and as due.

Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

PATIENT **DATE** **GUARANTOR** **DATE**

WITNESS **DATE**

Surgecenter of Louisville *an affiliate of* **SCA**
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PATIENT NAME	ACCOUNT RECORD	DATE

PROPOSED PROCEDURES

REFERRING M.D.	DATE OF BIRTH	AGE	SEX	SURGEON

CONSENT TO OPERATION AND OTHER MEDICAL SERVICES INCLUDING TRANSFUSION(S)

1. The facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, 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 facilities; 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 given with the understanding that any operation or procedure involves risks and hazards. The more common risks include: infection, bleeding with the need for 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 and direct the above named surgeon(s) and/or associates or assistants to perform the procedure(s) proposed above, and to arrange for such additional services for me as he/she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia, and the performance of pathology, laboratory, and radiology services, to which I hereby consent.
5. 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).
6. The facility may participate in residency and 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 my patient record by same.
7. **I DO / DO NOT** *(circle one)* authorize the administration of transfusions of whole blood or blood products to me as may be deemed advisable by the anesthesiologist, my attending physician and/or his associates or assistants. I understand that despite the exercise of due care the transfusion of blood or blood products is always attended with the possibility of some ill effects such as the transmission of hepatitis, HIV or certain other diseases, accidental immunization, or allergic reaction. I understand that in an emergency it may be necessary for the patient's well-being to use existing stocks of blood which may not include the most compatible blood types. *(If the patient circles* **DO NOT***, obtain the patient/guardian signature on the Refusal to Permit Blood Transfusion form)*
8. 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.
9. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me following my surgery. I acknowledge that I have been advised by facility personnel not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until the day after my surgery/procedure or as directed by my physician.
10. 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 participate in the actual procedure.
11. I consent to the use of video-taping 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.
12. I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility. I give consent to the removal of jewelry by the facility staff. I understand that damage to the jewelry may result from the removal process by cutting or physical removal. I acknowledge that I will not hold the facility responsible for expenses necessary to repair or replace the jewelry if indicated.
13. 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.
14. I am aware that my physician may have an ownership interest in the facility, and I acknowledge that I have a right to have the procedure performed elsewhere.
15. I understand that in the rare event the hospitalization is required during or immediately after surgery, my physician will arrange for my transfer to a local hospital.
16. I have not eaten or taken fluids, not even water, since DATE _______________ TIME _______________ AM / PM except for a sip of water taken with medication as instructed by my physician.
17. My signature below constitutes my acknowledgment 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 physician; (3) I authorize and consent to the performance of the procedure(s) and any 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).
18. 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. (a) 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 arising out of my lack of adequate authority to give this consent.

DATE _____________________ **TIME** ___________________ **PATIENT'S SIGNATURE** ____

DATE _____________________ **TIME** ___________________ **WITNESS TO SIGNATURE** ____

DATE _____________________ **TIME** ___________________ **PLANNED PROCEDURE VERIFIED BY** ________________________________

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

☐ Patient is a minor ☐ Patient is unable to sign because: ____

DATE _____________________ **TIME** ___________________ **SIGNATURE** ____

RELATIONSHIP ____

DATE _____________________ **TIME** ___________________ **WITNESS TO SIGNATURE** ____

DATE _____________________ **TIME** ___________________ **PLANNED PROCEDURE VERIFIED BY** ________________________________

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SURGEON	DOI	CLAIM#	ATTENTION

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REFUSAL TO PERMIT BLOOD TRANSFUSION

DATE____ Hour________________________________ AM PM

I request that no blood or blood derivatives be administered to ____ during my care, not withstanding that such treatment may be deemed necessary in the opinion of the attending physician or his assistants to preserve life, or promote recovery. I hereby release the facility, its personnel, and the attending physician from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its components and I fully understand the possible consequences of such refusal on my part.

____
(Signature of Patient)

____
(Witness)

When a patient is a minor or incompetent to give consent:

____
(Signature of person authorized to consent for Patient)

____
(Relationship to Patient)

____
(Witness)

ADVANCED DIRECTIVE/LIVING WILL/HEALTH CARE PROXY

I understand I have the right to make choices regarding life-sustaining treatment (including resuscitative-measures) and will check all boxes that apply to me:

- ☐ Yes, I have provided the Facility with a copy of my Advance Directive/Living Will/Health Care Proxy. The facility has explained to me their policy that if an adverse event occurs during my stay, based on reasons of conscience, all reasonable efforts will be taken to revive me, including resuscitative or other stabilizing measures and I agree to proceed with the proposed procedure as scheduled.
- ☐ I have an Advance Directive/Living Will/Health Care Proxy, but I have not provided the facility a copy. The facility has explained to me their policy that if an adverse event occurs during my stay, based on reasons of conscience, all reasonable efforts will be taken to revive me, including resuscitative or other stabilizing measures and I agree to proceed with the proposed procedure as scheduled.
- ☐ I do not have an Advance Directive/Living Will/Health Care Proxy. The facility has explained to me their policy that if an adverse event occurs during my stay, based on reasons of conscience, all reasonable efforts will be taken to revive me, including resuscitative or other stabilizing measures and I agree to proceed with the proposed procedure as scheduled.
- ☐ I wish to have information on how I can obtain an Advance Directive/Living Will/Health Care Proxy.

DATE ________________ **TIME** _______________ **PATIENT/AUTHORIZED AUTHORITY** _________________________________

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ANESTHESIA CONSENT FORM

I understand that anesthesia services are needed to undergo the operation or procedure. It has been explained to me that all forms of anesthesia involve some risks and no guarantee or promises can be made concerning the results of my procedure or treatment. **Although rare, unexpected severe complications with anesthesia can occur including the remote possibility of infections, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, blindness, heart attack or death.** I understand that these risks apply to **ALL** forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type{s) of anesthesia service checked below will be used for my procedure and that the anesthesia technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes anesthesia technique which involve the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

☐ General Anesthesia	Expected Result	Total unconscious state possible placement of a tube into the windpipe.
	Technique	Drug injected into the bloodstream, breathing into lungs, or by other routes.
	Risks (including but not limited to)	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, vomiting, aspiration, pneumonia.
☐ Spinal ☐ Epidural ☐ Regional Anesthesia / Analgesia	Expected Result	Temporary decreased or loss of feeling and/or movement to lower part of body, a specific limb or area.
	Technique	Drug injected through needle/catheter placed either directly into the fluid of the spinal canal or immediately outside the spinal canal, or injected near nerves providing loss of sensation to the area of operation.
	Risks (including but not limited to)	Headache, backache, buzzing in ears, convulsions, infections, persistent weakness, numbness, residual pain, injury to blood vessels, "total spinal".
☐ Monitored Anesthesia Care	Expected Result	Measurement of vital signs, availability of anesthesia provider for further intervention. Reduced anxiety and pain, partial or total amnesia, or total unconscious state.
	Technique	Drugs may be injected into blood stream, breathed into lungs, or by other routes, producing semi-conscious state.
	Risks (including but not limited to)	Awareness, anxiety and or discomfort, depressed breathing, injury to blood vessels, vomiting, aspiration, pneumonia.
☐ Conscious Sedation	Expected Result	Decreased level of awareness that allows toleration of an unpleasant procedure while maintaining the ability to spontaneously breathe and protect the airway.
	Technique	Drug injected into the bloodstream.
	Risks (including but not limited to)	Awareness, anxiety and or discomfort, depressed breathing, injury to blood vessels, vomiting, aspiration, pneumonia.
☐ Local Anesthesia ☐ Topical Anesthesia	Expected Result	Minimize pain and discomfort, while remaining fully conscious.
	Technique	Drugs may be topically applied or injected around and within the area to be treated, a brief stinging sensation related to the needle and/or the anesthetic being introduced. Within seconds, typically, the area becomes numb.
	Risks (including but not limited to)	Infection with potential for abscess formation, bruising or blood clot formation, injury to nearby structures, a reaction to the anesthetic agent, localized to the area, or general (systemic).

I consent to the anesthesia services indicated and authorize that it be administered by the anesthesiologist/CRNA of Prime Consultants, PLLC, all of whom are credentialed to provide anesthesia services at this healthcare facility. I also consent to an alternative type of anesthesia, as deemed appropriate by the anesthesia care team, I understand the importance of providing my health care providers with a complete medical history, including disclosure of any medications that I am taking, both prescription and over the counter. I also understand that my use of herbal remedies, alcohol or any type of illegal drug may give rise to serious complications and must be disclosed. I further understand that I should also disclose any complications that arose from past anesthetics. I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service, and that I had ample time to ask questions and consider my decisions.

____________________ Patient's Signature

____________________ Patient's Representative (Relative or Guardian)

____________________ Witness Signature

____________________ Relationship, if signed by person other than Patient

***The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign**

I hereby certify that I have explained the nature, purpose benefits, risk of, and alternatives to the proposed anesthesia, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered

____________________ Physician Signature

____________ Date

____________ Time