Consent to 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 agent 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 be 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 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, consent to testing for HIV and Hepatitis.

7. I hereby consent to the presence of other persons(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual procedure.

8. 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 a 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 at a local hospital.

12. My signature below constitutes my acknowledgment that:
   (1) I have read or have had read to me the foregoing, and I agreed 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).

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 arising 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 physician, 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 Pointe Surgery Center. I understand that by virtue of the assignment describe in the Consent, any funds I receive belong to NPSC and that it is UNLAWFUL to use or apply the 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 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 agreed 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.

Patient Rights and Responsibilities

20. I acknowledge that NPSC has provided me both verbally and in written form information on my rights and responsibilities as a patient (patient Bill of Rights) as well as information on Advance Directives for Health Care.

Medical Record Release Authorization

21. NPSC may disclose information about me and the treatment I am receiving, including copies of my medical record for purposes of treatment, payment and NPSC operations as described in our Privacy Notice. I acknowledge that the NPSC Privacy Notice have been offered to me. I agree to indemnify and hold harmless NPSC, its officers, directors, employees and agents, from any and all liability, loss claims or damages relative to the release of such information.

NOTICE OF PRIVACY PRACTICES (CHECK ONE BOX BELOW)

I acknowledge that I received the NPSC Notice of Privacy Practices that describes how my medical information may be used or disclosed as required by federal law.

I have previously received a copy of the NPSC Notice of Privacy Practices

Name of Patient: ______________________________________________________

Name of Responsible Party: _____________________________________________

__________________ ________________________________________________
Signature of Patient or Responsible Party Signature of Insured Person, if different than Patient

*If signed by Responsible Person, check one of the following:

□ Patient is unable to consent because he/she is a minor years of age

□ Patient is unable to consent because: