CSA SURGICAL CENTER

PATIENT NAME	ACCOUNT NUMBER	SURGEON	DATE OF SERVICE
PROPOSED PROCEDURE(S)			
PROPOSED PROCEDURE(S)			

CONSENT FOR TREATMENT AND RENDERING OF OTHER MEDICAL SERVICES, TESTING, AND RELEASE OF MEDICAL RECORDS.

1. I understand that medical procedures and operations may involve risks, unsuccessful results, serious complications, injury or even death, from both known and unknown causes, and no warranty or guarantee of success has been made regarding results or cures.
2. **My doctor has explained the nature of the surgery/medical procedure, the risks and benefits, possible complications, expected benefits or effects, and alternative treatment available to me and has answered all the questions that I asked. The information has been presented in a clear manner that I understand.**
3. I understand that I may have two (2) informed consents in my medical record, to meet regulatory compliance.
4. Except in cases of emergency, operations or procedures will not be performed until I have had the opportunity to receive this information and have given my consent.
5. In some cases, my doctor will not be able to identify ahead of time just what the additional surgery/medical procedure might be. I understand this. If there are surgeries or procedures that I do not want performed, I have informed my doctor.
6. I authorize my doctor to use additional associates, assistants, and other healthcare providers to assist with my surgery/medical procedure. My doctor may also assign or request additional assistance from anesthesiologists, other anesthesia providers, licensed medical residents in training or others who perform specialized medical care and treatment. My doctor has explained their role and involvement in my care and treatment.
7. I understand that the persons who perform these specialized medical services, such as anesthesia, radiology, or pathology, are independent contractors and, are not agents or employees of the Facility or my doctor. Since they are independent contractors, the Facility is not responsible or liable for their acts or omissions.
8. I understand that the Facility maintains personnel and equipment to assist my doctor with surgical operations and other special diagnostic or therapeutic procedures.
9. I consent to use of health care representatives designated by the physician to provide technical support for the equipment that may be used during the procedure.
10. _____ **YES** _____**NO** I authorize the presence of approved observers for my surgery/medical procedure. That includes medical /nursing students; medical school residents/interns; medical company equipment specialists; and other healthcare students. My doctor has discussed this with me and explained their role in my surgery/medical procedure. I understand that I have a right to privacy and that I do not have to agree to their presence during my surgery/medical procedure.
11. _____ **YES** _____**NO** I authorize the Facility staff or my doctor to photograph or videotape my surgery/medical procedure and use the prints, negatives or videotapes for purposes related to my healthcare, professional activities, or medical education. My identity will not be shown, and the photos, negatives and videotapes will be the property of the doctor or the Facility.
12. In case of an emergency, I authorize the Facility and my doctor to transfer me to another health care facility if medically necessary for my care. I also consent to the release of my medical records to and from that facility and to other doctors who will continue my care.
13. In the very rare event that a Facility employee or health professional has accidental exposure to my blood or other body fluids (for example, they are stuck by a needle with my blood on it), I authorize the Facility to draw my blood for testing for the presence of HIV/AIDS or hepatitis. I know I will not be charged for this testing. If tests show the presence of these illnesses, the results will be forwarded to my personal physician for confidential medical follow-up and treatment if needed, in order to protect my health and the health of my family. Additionally, the Facility will offer medical care to the involved employees or healthcare professionals. All tests and test results will be handled in a strictly confidential manner.

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14. Should I require the implantation (surgical placement) of a medical device, I give the Facility permission to release the appropriate information to the manufacturer of the device in order to assist the manufacturer in contacting me regarding the device is such contact is necessary.
15. I authorize the pathologist to use his/her discretion in disposing of any member, organ, or other tissue removed from my body during the surgery/medical procedure.

LOCAL PROCEDURES ONLY – (check **ANY** if applicable)

☐ I consent to the administration of local or topical anesthesia as the primary analgesia for the procedure referred to above. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, muscle soreness, cardiac stimulation, hypotension, cardiac arrest, seizures, tinnitus, disorientation, and temporary or rarely, permanent numbness.

☐ I consent to the administration of sedation/analgesia administered by a registered nurse, who is under the direct supervision of the physician. I understand that the administration of sedation/analgesia is to reduce anxiety and discomfort. Untoward effects of sedation/analgesia may include but are not limited to cardiac or respiratory depression, headache, and nausea.

COVID-19. I understand the Novel Coronavirus (COVID-19) is a relatively new virus and the medical community is still trying to understand how it spreads, develop effective treatments and/or vaccines, and otherwise understand the risks associated with performing surgeries/medical procedures during the COVID-19 outbreak. I also understand that the Facility has implemented reasonable safeguards to help reduce the spread of COVID-19, but safeguards may not be 100% effective against this extremely contagious virus. I acknowledge that my physician has explained to me the relative risks involved with my surgery/medical procedure related to Novel Coronavirus (COVID-19), including the possible transmission of COVID-19 during my surgery/medical procedure, delaying my surgery/medical procedure until after COVID-19 is less prevalent, and possible complications that may arise related to my surgery/medical procedure and transmission of COVID-19. I understand that COVID-19 testing is not 100% accurate; the test may fail to detect the virus and I could still have the virus even if I do not have any symptoms. I also understand that if I do have the COVID-19 infection this may lead to a higher complication rate for my surgery/medical procedures or even death. If I am exposed to COVID-19 before, during, or after my surgery/medical procedure, I acknowledge that it may result in one or more of the following: (1) a positive COVID-19 diagnosis; (2) isolation, additional tests, and hospitalization (including possible admission to the intensive care unit (ICU), intubation and ventilator support); or (3) death. By signing below, I certify that I accept the risks associated with proceeding with my surgery/medical procedure during the COVID-19 outbreak and I do not want to delay my surgery/medical procedure to a later date.

My signature below certifies (1) that I have read and understood the information provided in this form; (2) that the surgery/medical procedure noted above has been adequately explained to me by my doctor; (3) that I have had a chance to ask questions: (4) that I have received all of the information I need concerning the surgery/medical procedure; (5) that I accept any substantial and significant risks of the procedure: and (6) that I authorize and consent to the performance of the surgery/medical procedure(s).

Signature:____ **Date/Time:** ______________________
Patient or Authorized Representative

Witness: ____ **Date/Time:** ______________________
(Signature)

Physician:____ **Date/Time:** ______________________
(Signature)

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