CLERMONT AMBULATORY SURGICAL CENTER
AUTHORIZATION AND CONSENT TO SURGERY AND/OR OTHER MEDICAL SERVICES

Florida State Law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advise but as a member of the health care team, you must enter into the decision-making process. This form has been designed to acknowledge our acceptance of treatment recommendations by your physician at Clermont Ambulatory Surgical Center (hereinafter CASC).

1. **Consent to Surgical or Diagnostic Procedure:** I acknowledge that I have directed my physician (, and /or associates or assistants of his/her choice to perform the following operation and/or diagnostic procedure(s) on me:

   and/or such operation(s) or any other therapeutic procedure(s) upon me which they may deem necessary or advisable. My physician or his/her designee has explained to me the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards including bleeding, infection inherent in the proposed operation(s) or procedures(s). Based on the information provided by my physician or his/her designee, I have a general understanding of the operation to be performed on me and that no warranty or guarantee has been made as to the result or cure.
2. **Consent to Other Medical Services:** I hereby authorize and direct the above named physician and his/her associates or assistants to provide such additional services for me as he/she may deem necessary or advisable including, but not limited to, the performance of services involving pathology and radiology and I hereby consent to all such additional services.
3. **Authorization to Release Medical Information:** I hereby authorize CASC, Florida Anesthesia and Pain Management Associates, LLC, (FAPMA), my insurance company, any treating physicians and my attorney, when applicable to obtain, use and/or release information for the purposes of treatment, payment, and/or operations, as outlined in the Notice of Privacy Practices. This may include collection agencies, credit bureaus, and myself, and will be limited to the minimum amount necessary. I hereby authorize CASC to obtain PHI from other facilities, if needed, for the continuation of my care or for the follow up care related to my procedure or visit at CASC.
4. **Consent for Anesthesia Services:** I understand that anesthesia services are needed in most cases so that my doctor can perform the procedure. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, dental injuries, blood clots, loss of sensation, loss of limb function, stroke, brain damage, heart attack or death. I understand that these risks apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service used for my procedure and that the anesthetic 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. This will be discussed and explained to me with the anesthesia personnel prior to my procedure. I hereby consent to anesthesia services to be provided to me from FAPMA, all of whom are credentialed to provide anesthesia services at CASC.
5. **Photography/Observation:** Here at CASC, I understand that medical personnel and students may observe my care under the supervision of a qualified instructor, physician and /or registered nurse. For the purpose of advancing medical knowledge, I consent to the admittance of healthcare students and technical representatives under supervision in accordance with ordinary practices of CASC. Some procedures may be photographed or videotaped for medical documentation and/or to enable the surgical team to visualize the procedure.
6. **Diagnostic Laboratory Testing:** I hereby consent to diagnostic laboratory blood testing (i.e. HIV, Hepatitis) as designated by my physician for the purposes of treatment, safety and accidental exposure. I understand these test results will be kept confidential and only those required or permitted by law will know the results and my identity and that my physician will inform me of my test results and any follow-up testing/care required.

DOB: **DOS:**

7. **Tissue Disposal:** I hereby consent to the removal and examination of appropriate tissue during surgery and authorize the physician and/or pathologist to use his/her discretion in the disposal of any severed tissue, member, organ or hardware removed from me during the operation or procedure described above.
8. **Consent to Transfer:** This is to certify that I voluntarily consent to be transferred from CASC to a regional hospital if deemed necessary, by my physician for continued medical care. I consent to authorize the release of information for medical necessity for transport to a higher level of care. I hereby forever release CASC, its employees, representatives, other facility authorities and the attending Physician from any and all claims and actions for damages, of whatever kind, cause of nature, resulting from the transport to the hospital and care received after I leave CASC.
9. **Patient Rights and Responsibilities and Notice of Privacy Rights and Practices:** I acknowledge that I have been provided a copy of both and understand my patient rights and responsibilities and patients' privacy rights and practices. I consent CASC to disclose protected health information about me for treatment, payment and health care operations as described in CASC Notice of Privacy Rights and Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Please indicate below (by name and relationship) the person(s) with whom we may discuss your protected health information;

_____

10. **Assignment of Benefits:** I hereby assign all my insurance benefits under the described policies and authorize CASC and FAPMA to bill for charges incurred and to provide any medical information necessary to process this claim. I authorize payment to be made directly to CASC and FAPMA. I understand that I am responsible for all charges, even if I have insurance coverage including co-payment and /or deductible.
11. **Medicare Part B Signature Authorization Release of Information and Payment Request:** Medicare patient-I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I request payment under the medical insurance program to be made either to me or CASC to inquire about and receive any information about any and all of my Medicare Part B claims, assigned and/or assigned.
12. **Notice of Disclosure of Ownership Interest:** CASC is owned by Healthcare Services of Fl. and two local physicians, Leonor Santos, M.D., and Richard Smith, M.D. one of whom may be your physician. These physicians have become owners to ensure their patients receive quality health care and services. Under Florida Law, a physician-owned facility may not provide items or services unless the patient signs a written notice disclosing certain matters. A schedule of typical fees for services provided by CASC is available at your request. You have the right to have your procedure performed at any other facility where your physician has privileges.
13. **Advance Directives:** Ambulatory Surgery Centers perform predominantly elective procedures. CASC, as per our policy, will not honor any patient or family request for a "No Code" or "DNR" for any procedure scheduled at the facility. We will keep a copy of any Advance Directive on the patients chart if provided to us. In case of transfer of patient to another healthcare facility, CASC will send a copy of the Advance Directive to the receiving medical facility.

_____ _____

Patient's Signature or Legal Authorized Representative **Date/Time** **Witness** **Date/Time**

DOB: **DOS:**