The Surgery Center at Lutheran

Conditions of Service / Consent for Treatment

1. The Surgery Center maintains personnel and facilities to assist your physician(s) in his or her performance of various surgical operations and other special diagnostic or therapeutic procedures and/or treatment. These procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure.

   You have the right to be informed of such risks as well as the nature of the operation, procedure and/or treatment; the expected benefits or effects of the same; and the available alternative methods and their risks and benefits. Except in cases of emergency, operations, procedures and/or treatments are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent or to refuse any proposed operation, procedure and/or treatment any time prior to its performance.

2. The operation, procedure and/or treatment will be performed by my physician (or in the event of an emergency causing his or her inability to complete the procedure, a qualified substitute physician or surgeon), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff to whom the physician or surgeon may assign designated responsibilities. The person in attendance for the purpose of performing specialized medical services such as anesthesia, radiology, or pathology are not agents, servants, or employees of the Center or your physician or surgeon, but are independent contractors and, therefore, your agents, servants, or employees.

3. The pathologist is hereby authorized to use his or her discretion in disposing of any member, organ, or other tissue removed from your person during the operations or procedures set forth above.

4. **Advance Directives:** I understand that even though the physicians and staff of the Surgery Center respect my rights to participate in decisions regarding my health care, the policy of the Surgery Center is that all patients undergoing surgical procedures will be considered eligible for life-sustaining emergency treatments.

5. **In the event of an emergency or urgent situation:** I consent to the transfer and/or admission to a nearby acute-care facility for continuity of care. *In the case of an emergency transfer to another facility or hospital, I consent to the use of blood and/or blood by-products at the receiving facility.* **(Initial** on the appropriate line)

   ★ _______**Yes**, I agree to a blood transfusion if needed in an emergency.
   _______ **No**, I refuse a blood transfusion even in an emergency.

   In the Case of an Emergency:

   Notify my next of kin: Name: ★ ______________________________ Phone: ★ _________________

6. **Accidental Exposure:** 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. **Health Plan Obligation:** This Center maintains a list of health plans with which it contracts. A list of such plans is available upon request from the Administrative Office of this Center. The Center has no contract, expressed or implied, with any health plan that does not appear on the list. The undersigned agrees that she/he is individually obligated to pay the full charges of all services rendered to him/her if he/she belongs to a plan that does not contract with the Center. If my insurance is Medicare, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Administration Act is correct.

8. **Investors:** Your physician may be an investor in The Surgery Center at Lutheran. The receptionist, upon request, can provide more details regarding the ownership of the Center.

Patient Label

9. **Permission to Discuss Financial Information:** I authorize (name of another adult other than myself) ★ ______________________________, to discuss my account information with the Surgery Center at Lutheran. I understand that conversations will be limited to account balance, claim/personal payment, insurance benefits and insurance coverage. Medical information will not be discussed without further documented authorization.

10. **Ride Arrangements:** I have made arrangements to have a responsible adult drive me home and care for me for the next 24 hours.

11. **During your stay with us:** While you are at the Center we are committed to running on time. If you have been waiting for more than 15 minutes after your initial check-in, please alert the receptionist, who will check into the delay. The Center shall not be liable for the loss or damage to any money, jewelry, documents, dentures, glasses, hearing aides, clothing, etc. or other personal articles. Regarding the use of Cell Phones, they are prohibited in the surgical areas. The Surgery Center requests that usage be limited to the waiting area.

12. **Permission:** During your time at the Center and during your convalescence, the doctors and nurses are concerned about your care and may need to talk with your significant others to provide for the very best surgical outcome. Whom can we talk to: ★ __________________________________

   ★ _______ Yes, my doctor or nurse can talk to my family/friends
   _______ Yes, my doctor or nurses may leave messages on my home phone, if I can not be reached

13. **Payment:** This Center expects each patient to pay his or her deductible and co-pays on or before the day of surgery. Once the insurance company has adjudicated the claim, patients will be responsible for all remaining balances. The Surgery Center at Lutheran will allow patients up to three months to pay off the remaining balance. It is the responsibility of the patient to contact the Business Office Manager, to request a 3-month payment plan.

14. **Authorization:** The undersigned certifies that he/she has read the foregoing, received a copy thereof, and as the patient, or the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. The signature constitutes your acknowledgement that (1) you have read and agree to the foregoing; (2) that the operation, procedure and/or treatment has been adequately explained to you by the physician; (3) that you authorize and consent to the performance of the operation, procedure and/or treatment at this facility; (4) that you have read the Patient's Rights and Responsibilities. When signing this form you are consenting to the performance of all routine medical/surgical care and treatment (e.g., physical examination, tests, x-rays, therapy, etc.) which may be performed while a patient at The Surgery Center at Lutheran, as well as emergency treatment or services that may be required under the general and special instructions of the patient's physician or surgeon.

★ ______________________________________ ★ ______________ ★ ______________

Signature (patient/parent/guardian) Date Time

______________________________________ ______________________________

Witness Signature (**if signed by other than patient**) Relationship to patient

I have received information in language I understand and have been given an opportunity to ask questions about: Please **initial** the items that apply.

★___Advance Directives _____I have provided a copy of my Advance Directives to the Surgery Center
★___My Rights and Responsibilities as a patient
★___My physician's part ownership in the Surgery Center
★___HIPAA/Notice of privacy practices