SURGERY CENTER OF POTOMAC LLC

Authorization for and Consent to Surgery and Anesthesia
Financial Responsibility Agreement

1. The surgeon who will be performing your surgery or procedure is Dr. _____.
2. The Center maintains personnel and facilities to assist your surgeon in the performance of various surgical operations and other procedures. You acknowledge that the surgery or procedure being performed is purely voluntary. Any surgery or procedure involves risks of unsuccessful results, complication, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result. You have the right to be informed of such risks as well as the nature of the surgery or procedure and the expected benefits or effects of such risks as well as the nature of the surgery or procedure and the expected benefits or effects of such surgery or procedure. Surgery or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or to refuse any proposed surgery or procedure at any time prior to its performance.
3. Your surgeon will be performing the following voluntary surgery or procedure(s):
   _____
   _____Upon your authorization and consent, this voluntary surgery or procedure will be performed on you. In the event of an emergency during your surgery or procedure, you will be transferred to a hospital to receive care. The surgery or procedures will be performed by the surgeon named above (or in the event that such surgeon is unable to perform or complete the procedure, a qualified substitute surgeon), together with associates and assistants, including anesthesia providers, from the staff of Surgery Center of Potomac to whom it may assign designated responsibilities. [The persons in attendance for the purpose of performing specialized medical service such as anesthesia or pathology are not agents, servants, or employees of the Center or your surgeon. They are independent contractors and therefore are your agents, servants, or employees.]
4. You will be administered local or general anesthesia as part of your surgery or procedure. Any administration of anesthesia involves risks of complications or even death. If you have any sensitivities or allergies to anesthesia of any kind, please inform your anesthesia provider.
5. It is unlikely, however, in the event of an emergency, you may need a blood transfusion as a result of the surgery or procedure to which you are consenting. The Surgery Center does not maintain any blood supply, and in the event a transfusion is needed, you will immediately be transferred to a hospital for such treatment. The hospital will be responsible for explaining the risks of receiving a transfusion.
6. By your signature below, you authorize the surgeon to submit any appropriate tissues or other specimens to pathologist for review, and for the surgeon and pathologist to use his or her discretion in the disposition of any such tissues or specimens.
7. To make sure that you fully understand each surgery or procedure, you physician will fully explain the surgery or procedure to you before you decide whether or not to give consent. If you have any questions, you are encouraged and expected to ask them.
8. Your signature to this form indicates that: (1) you have read and understood the information provided in this form; (2) the surgery or procedure set forth above and the associated administration of anesthesia has been adequately explained to you by your surgeon and anesthesia provider; (3) you have had a chance to ask questions;(4) you have received all of the information you desire concerning the surgery or procedure and administration of anesthesia; (5) you authorize and consent to the performance of the operation or procedure and administration of anesthesia.
9. I hereby authorize the Surgery Center of Potomac to furnish information to insurance carriers concerning this admission, and I hereby irrevocably assign to the Surgery Center of Potomac all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. I understand and agree that interest of 1,5% per month (18% annum) will be added as a late charge for any account not paid within 30 days of when the balance is due. If my account is referred to an attorney for collections I agree to pay any reasonable legal fees (25% is deemed reasonable), court costs, and other collection expenses. I certify that the information provided about my Insurance Company is correct. I authorize the release of medical information requested by my Insurance Company. A copy of this authorization shall be considered as valid as the original.

Signature _____(Patient/Parent/Conservator/Guardian)

Date: _____Time:_____ Witness:_____

If signed by other than patient, indicate relationship: _____Translator: _____

PHYSICIAN/ANESTHESIA PROVIDER VERIFICATION OR INFORMED CONSENT

- ❑ The nature of the surgery or procedure (by the surgeon) and the associated administration of anesthesia (by the anesthesia provider); its expected benefits; potential risks and complications; were discussed with the patient (or with the patient's legal representative) prior to the surgery or procedure. All questions were answered to the patient's (or to the patient's legal representative) satisfaction and the patient gave informed consent to the surgery or procedure.

Date: _____Time: _____ Surgeon Signature: _____

Date: _____Time: _____ Anesthesia Provider Signature: _____

Revised S.Day 06/2007