MILE HIGH
SURGERY CENTER
LLC

Patient Label Here

Proposed Procedure

Surgeon | **Date of Birth** | **Sex**

INFORMED CONSENT TO OPERATION AND OTHER MEDICAL SERVICES INCLUDING TRANSFUSION(S)

**The facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of the facility, but independent contractors and therefore are the patient's agents or servants. The facility provides nursing and support services; the facility does not provide medical physician care.

**The procedure(s) listed to be performed and the advantages and disadvantages, risks and possible complication as well as the alternative have been explained to me by my physician. The physician has satisfactorily answers my questions. 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 blood transfusion, nerve injury, blood clots, heart attack, stroke, allergic reactions, damage to teeth or bridgework, and pneumonia. These risks can be serious and possibly fatal. I authorize and direct the above-named surgeon to arrange for such additional services for me as he/she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of pathology or radiology services, to which I hereby consent. I authorize the pathologist or physician to use his/her discretion in disposing of any member, organ, implant, prosthetic, or tissue removed from any person during the operation(s) or procedure(s).

**In the event of an accidental exposure of any blood or bodily fluid to a physician, contractor or employee of the facility, I consent to testing for HIV and Hepatitis.

**I understand that it is my responsibility and that I have arranged for a responsible adult to drive me home and remain with me following my surgery. I acknowledge that I have been advised by the facility personnel not to drive until all effects of medication have worn off. I understand this to mean that I should not drive until the day after my surgery / procedure or as directed by my physician.

**I hereby consent to the presence of other person(s) for the sole purpose of assisting the physician during the operation / procedure. These other practitioners include: Surgical Assistant_____ Physician Assistant_____
Resident/Fellow_____ Other_____

**I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I have brought into the facility.

**I understand that if I am pregnant or if there is any possibility that I may be pregnant, I must inform the facility immediately since the scheduled operation / procedure could cause harm to my child or myself.

**I am aware that my physician may have an ownership interest in the facility, and I acknowledge that I have a right to have the operation / procedure performed elsewhere.

**I understand that in the rare event that hospitalization is required during or immediately after the surgery, my physician will arrange for my transfer to a local hospital.

**My signature below constitute my acknowledgement that:

1) I have read or have had read to me the foregoing and I agree to it.
2) The operation(s) / procedure(s) has been adequately explained to me by my physician.
3) I authorize and consent to the performance of the operation(s) / procedure(s) and any additional procedure(s) deemed advisable by my physician in his/her professional judgement.
4) I authorize and consent to the administration of anesthesia for the said operation(s) / procedure(s).

******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. A) I have full right to consent to the matters above, and consent to the same; B) I hereby indemnify and hold harmless the facility, it's employees, agents, medical staff, partners and affiliates from any other cost or liability arising out of my lack of adequate authority to give this consent.

Date:_____ Time:_____ Patient Signature:_____

If patient is a minor or unable to sign, please complete the following:
Patient is unable to sign because: O Patient is a minor O Other:_____

Date:_____ Time:_____ Signature/Relationship:_____

Date:_____ Time:_____ Witness to Signature:_____

PHYSICIAN'S AFFIRMATION OF CONSENT: I certify that I have informed the patient or his/her representative of the nature of this operation / procedure, alternative methods thereto, including non-treatment, and the risks associated therewith.

Physician Signature:_____ Procedure read aloud prior to start of surgery: Time_____ Initials_____