Affix patient sticker here

Conditions of Outpatient Admission

Please read each section carefully and then sign and date

Consent to rendering medical services/release of information
Authorization: Release of information/financial responsibility/benefit assignment
Information: Patient Bill of Rights & Responsibilities/Patient Instruction Sheet

1. I the below named patient hereby authorize the below-named surgeon and/or his/her associates of his/her choice to perform operation indicated on the operative consent and/or such operations or any other therapeutic procedure upon me they may deem necessary or advisable. The necessity for the operation and the potential risks of the operation have been explained to me by my physician and no warranty or guarantee has been made as to the result or cure.
2. I hereby authorize the below-named surgeon and/or his/her associates or assistants to provide such additional services for me as he/she or they may deem necessary or advisable including procedure different from those now contemplated, and including but not limited to the administration and maintenance of anesthesia, nursing services, radiological and pathological services, and photography, videotaping and recordings of the operation for medical or educational purposes. I understand that in certain circumstances it may be necessary for a Health Industry Representative to be present in the operating room to consult with the operative team.
3. I hereby authorize the below-named surgeon to use his/hers discretion in the retention, preservation or disposal of my severed tissue or member except:_____.
4. I hereby authorize all doctors, pharmacists, hospitals, Select Surgical Center at Kennedy or other institutions rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered (including copies of my records). A photostatic copy of this authorization shall be considered as effective and valid as the original.
5. I have reviewed a copy of the Patient Bill of Rights/Patient Responsibilities and understand my rights as stated.
6. I understand that the surgical and/or diagnostic procedure to be performed on me at Select Surgical Center at Kennedy will be done on an outpatient basis and that this facility does not provide 24-hour inpatient care. If my attending practitioner, or any other duly qualified physician in his/her absence, shall find it necessary or advisable to transfer me from this facility to a hospital or other health care facility, I consent and authorize the employees and this facility to arrange for and effect the transfer. I also authorize the hospital/treatment facility to which I am transferred to release treatment information, including the discharge summary, to Select Surgical Center at Kennedy.
7. I authorize Select Surgical Center at Kennedy to release information, including any record, bills for services rendered, opinions, reports, x-rays in my medical chart, with respect to the treatment of the above-referenced patient, including any confidential HIV-related information, to any third party who may be responsible for the payment or inquiry of my account, any alternative care-giver, and any accrediting review agencies as may be necessary.
8. I understand I am financially responsible to Select Surgical Center at Kennedy for any charges incurred by the below named patient and promise to pay promptly the Select Surgical Center at Kennedy the amount of such charges which are not paid by any insurance carrier for any reason. I agree that in the event my account should become delinquent, I will pay all reasonable attorney fees, court costs and other expenses pertaining to the collection of such account whether or not a law suit is commenced in connection with collection efforts.
9. I was given an instruction sheet including information necessary to facilitate my preoperative and postoperative care. I understand and agree to abide by the instructions contained in the sheet.
10. I understand that any Advanced Directive I may have will not be honored at Select Surgical Center as this is an outpatient surgery center and all measures necessary for resuscitation will be executed at this center.

Signature of Patient/Legal Guardian:_____
Name of Patient (please print)_____
Witness to Signature:_____
Date:_____ Time:_____am / pm (circle one)

If financial responsible/insured person is other than patient/legal guardian please sign below:

_____ _____

Financially responsible/insured person's Signature **Witness Signature**