Affix patient sticker here

Informed Consent for Surgery Or Other Diagnostic Procedure

1. I hereby authorize Doctor _____or any other physician he/she may designate to perform the following surgery or diagnostic procedure on me:
_____

_____
2. If any unforeseen condition arises in the course of the above procedure which in his/her judgment calls for procedures in addition to or different from those now contemplated, I further request and authorize his/her or his/her designates to do whatever they deem advisable.
3. In the performance of the above surgery or diagnostic procedure, I consent to the administration of anesthesia, pre-operative therapy and medication as indicated. I understand that anesthesia involves the possibility of loss of life or permanent disability. I certify that no warranty, guarantee or assurance of any kind has been made to me.
4. I consent to disposition by the Select Surgical Center at Kennedy of any tissues or parts which may be removed.
5. For the purpose of advancing medical education, I consent to the admittance of qualified observers to the Operating Room, to the taking and publication of any photographs in the course of this operation and to the use of my medical records.
6. Surgical Residents and/or Fellows may be involved in the performance of your surgical procedure under the supervision of the Attending Surgeon.
7. I acknowledge that the comparative risks, benefits and alternatives associated with performing this procedure in an ambulatory surgery center instead of a hospital have been fully explained to me.
8. Should a blood borne exposure occur during the procedure, I consent to the drawing of blood for HIV and hepatitis testing. The results of the test will be placed in my medical record and protected in accordance with applicable laws.
9. I acknowledge that no guarantee has been made as to the results that may be obtained. The nature and purpose of the above procedure, possible alternative method of treatment, the risks involved and the possibility of complication including, but not limited to, infection, hemorrhage, non-healing, have been fully explained to me.
10. I am aware that my physician **does / does not** have ownership interest in the Select Surgical Center at Kennedy. If I choose to go to another health care facility for this procedure, it will have no effect my relationship with my physician.
11. I am aware that the Center does not recognize Advanced Directives while I am a patient in the Center.

I certify that I have read and fully understand the above **INFORMED CONSENT FOR SURGERY OR OTHER DIAGNOSTIC PROCEDURE**, that the explanations there in referred to were made, and that all blanks and statements requiring insertions or completions were filled in. The inapplicable paragraphs, if any, were stricken before I signed.

Signature of Patient:_____
Name of Patient (please print)_____
Witness to Signature:_____
Date:_____ Time:_____am / pm (circle one)
Surgeon's Signature_____ Date:_____ Time:_____ am/pm

If the informed consent cannot be signed by the responsible patient, have the authorized person sign below:
I certify that I am legally empowered to act for the above patient, and do consent to the procedure as stated above.
Signature:_____
Relationship to the Patient_____
Witness to Signature:_____
Date:_____ Time:_____am/pm
Surgeon's Signature_____Date:_____Time:_____am/pm