Orthopaedic Specialists Surgi-Center Facility
Patient Consent and Authorization

1. Release of Information: I agree that the Facility may disclose my "protected health information" (PHI) in compliance with HIPPA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or my employer. This includes appropriate release of and disclosure of my medical records in compliance with privacy provisions to my physicians and other health care providers when necessary for my treatment and general health.
2. I hereby authorize consent to care: I am presenting myself to Orthopaedic Specialists Surgi-Center for care. I hereby voluntarily consent and authorize such care, including diagnostic procedures, surgical and medical treatment by authorized agents and staff members of this surgical center and by its medical staff or their designees as may in their professional judgment be necessary and beneficial. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my condition.
3. Notice of policy regarding advance directives: I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore in accordance with Federal law, the facility is notifying you that it will NOT HONOR previously signed advanced directives/living wills/durable power of attorney.
4. I understand that if any complications occur during or immediately following my admission I may require transfer to a hospital. Arrangements for such transfer will be made by the OSSC. I agree to pay the charges made by the transport company.
5. I agree to allow x-rays to be taken and read by a radiologist if necessary. I agree to pay the charge made by the Radiologist.
6. I agree to allow any photographing or videotaping deemed necessary by my surgeon. I understand these photographs and/or videotapes are the property of OSSC.
7. **I understand that I am going home after surgery and that a responsible person will remain at the facility the entire duration of my stay, and will drive me home and take care of me. If I need to travel by taxi, I will have a friend or relative accompany me.**
8. Assignment of Benefits: For services rendered at OSSC, I hereby assign payment directly to OSSC of all benefits applicable and otherwise payable to me by my insurance company(ies).
9. I understand that there will be separate bills from my physician(s), facility, anesthesiologist and/or anesthetist, pathologist, and/or laboratory. {____} **(PLEASE INITIAL)**
10. Financial Agreement: I understand that whether signing for myself or my dependent that I am financially responsible for the services provided. I understand that OSSC verifies the eligibility of my health insurance benefits, and for the payment by my health insurance for the services that I am scheduled to receive, but I also understand that eligibility of such benefits and services rendered will be determined by my insurance carrier when the bill for services rendered is submitted for payment. I understand that if I do not pay my bill(s) within 90 days, or arrange a payment plan that is acceptable with OSSC, my account will be placed with a collection agency and/or attorney, and I will be responsible for all collection expenses, as permitted by law.
11. Medicare certification, authorization to release information, and payment request: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.
12. A copy of this consent shall be considered as effective and valid as the original.

13. I have been given the opportunity to read the Surgi-Center's Patient's Bill of Rights and/or have requested and received a written copy of same.
14. HIPAA privacy notice: I acknowledge that I have received the Facility's HIPAA Privacy Notice and have had the opportunity to review its content. **{_____} (PLEASE INITIAL)**
15. I wish to be treated at OSSC, and I understand that the physician who referred me to this facility has a financial relationship with the center. **{_____} (PLEASE INITIAL)**
16. I consent that discharge instructions will be provided in the curtained environment of PACU. **{_____} (PLEASE INITIAL)**
17. I have been informed that an outside observer, under the direct supervision of my surgeon may be present during my procedure. I acknowledge that I have the right to allow or refuse the presence of this representative during my procedure. My doctor has discussed this with me and explained their role in my surgery/medical procedure. I understand that I have a right to privacy and that I do not have to agree to their presence during my surgery/medical procedure.
18. In the event of an accidental needle stick I have been informed that my blood will be tested in order to detect whether or not I have antibodies and/or antigens in my blood to the Human Immunodeficiency Virus (HIV), Hepatitis, Syphilis or other blood borne pathogens. I understand that the results of this blood test are confidential and will only be released to the health care practitioners directly responsible for my care and treatment and to others as required by law. I further understand that no additional release of the results will be made without my written authorization**.** I further acknowledge that I have given consent for the performance of a blood test to detect antibodies to HIV, Hepatitis, Syphilis or other blood borne pathogens.
19. I agree that the surgery/medical procedure(s) noted above are correct, and the correct body part is noted (if applicable.)
20. My signature below constitutes my acknowledgement that I have read or have had read to me the foregoing and understand.

Patient/ Parent/ Legal Guardian Signature: _____

Relationship: _____ **Date: _____**

Witness: _____