

SURGICAL INFORMED CONSENT FORM

CONSENT UPON ADMISSION FOR TREATMENT

I, _____, do voluntarily consent to the following medical procedure(s):

Treating Doctor and Facility. The procedure will be performed by my Treating Doctor, Dr. _____, at NovaMed Surgery Center of Chicago NorthShore. I have been informed that there are physicians who may have ownership in this surgery center. I understand that I am free to choose another facility in which to receive services. I also understand NovaMed Surgery Center of Chicago NorthShore is (arranging) for the equipment, technical support and clinical staff to be used in performing this procedure.

Basis of Consent. I give this voluntary consent after discussing with my Treating Doctor and agree that the procedure is an appropriate course of medical treatment. In particular I have discussed with my Treating Doctor my general medical condition and allergies and I have informed my Treating Doctor about any medication (including prescription and over-the-counters medications) that I am currently taking. My Treating Doctor has fully explained the following:

- the nature and purpose of the procedure,
- the material risks of the procedure,
- the benefits from the procedure,
- the possibility of complications during the procedure,
- the alternative treatments and procedures available, and
- the consequences of refusing the procedure.

I know that I may make requests for additional information about any of the above issues prior to the commencement of the procedure. I also know medicine and surgery are not exact sciences and that no guarantees can be made concerning the results of the procedure. My Treating Doctor has obtained my informed consent to the procedure. If I should have any questions or concerns regarding the nature or results of the procedure or any other examination or treatment, I understand that I should ask my Treating Doctor.

Consent for Additional Procedures. I also give voluntary consent for any necessary routine diagnostic procedures and medical treatment performed by my Treating Doctor as part of the above medical procedure. I also consent to the performance of other unforeseen operations or procedures if my Treating Doctor determines they are required. Such a situation may arise, for example, if the procedure or surgery discussed above discloses a previously unknown condition and my Treating Doctor determines, based on medical judgment, the unforeseen operation or procedure is reasonably necessary to improve or maintain my health. I also understand other necessary medical professionals, designated by my Treating Doctor, may also participate in my procedure.

Consent to Experimental or Investigational Procedures: My Treating Doctor has fully explained to me that my procedure or implant may be considered investigational and/or experimental in nature by third party payor(s).

Anesthesia. I understand that certain risks attend all anesthetics and medications. My Treating Doctor has explained to me that this procedure will be conducted while I am under one of the following types of Anesthesia:

Monitored Anesthesia (sometimes referred to as “conscious sedation” in which the patient is conscious but fully sedated)

Local Anesthesia (medicine given to temporarily stop the sensation of pain in a small, particular area of the body)

Topical Anesthesia (commonly administered through eye drops or cream applied to the skin)

Anesthesia provider’s signature

The risks and benefits of this type of anesthesia as well as the alternatives to receiving the recommended anesthesia have been explained to me. I consent to the administration and performance of such anesthesia, and the administration of other necessary or advisable medications, under the direction of the physician who is responsible for this service. I understand the anesthesiologist or CRNA performing the anesthesia services has been granted privileges to provide these services at NovaMed Surgery Center of Chicago NorthShore , but may not be an employee of NovaMed Surgery Center of Chicago NorthShore or any affiliates.

Transportation and Care After the Procedure. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and provide assistance following my surgery. I acknowledge that I have been advised not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until the day after my procedure or as directed by my Treating Doctor.

Educational Use Authority. I give permission for medical data concerning my procedure and subsequent treatment to be used in clinical teaching by the Treating Doctor and others participating in my procedure and give permission to the photographing, videotaping or televising of my surgery for teaching purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them. For the purpose of advancing medical education, I consent to the admittance of observers approved by the Facility’s Director in the operating room. Under supervision of my Treating Doctor, I authorize clinical coaching of personnel in relation to my patient care.

Disposal of Medical Tissue. I consent to the disposal of any tissue removed during the procedure in accordance with customary practices.

Additional Testing of Blood. In the event someone associated with my procedure becomes accidentally exposed to my blood or bodily fluids – such as in the case of an accidental needle stick or direct contact with their skin or mucous membrane with my blood or bodily fluids – I consent to the testing of my blood for blood-borne pathogens, including HIV and Hepatitis.

Advance Directives. I understand that advance directives are not honored at NovaMed Surgery Center of Chicago NorthShore . I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advanced directive or living will, the surgery center will still transfer me to a hospital which will make the decisions about following any advanced

directive or living will. If I should be transferred to a hospital, I authorize to the hospital to release copies of my medical records to the surgery center to review the episode of care.

I have the following:

Copy given to Surgery Center

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|--|--------------------------|
| <input type="checkbox"/> Living Will | <input type="checkbox"/> |
| <input type="checkbox"/> Health care surrogate, proxy or durable power of attorney | <input type="checkbox"/> |
| <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> |
| <input type="checkbox"/> Evidence of Guardianship | <input type="checkbox"/> |
| <input type="checkbox"/> None of the above | |

Legal Relationship between Surgery Center and Physicians. I understand that all physicians furnishing services to the patient, including my Treating Doctor, and any specialist such as an anesthesia provider, radiologist and pathologist are independent contractors with the patient and are not employees or agents of NovaMed Surgery Center of Chicago NorthShore . I understand that I am under the care and supervision of my Treating Doctor and that the surgery center and its staff carry out instructions of my Treating Doctor.

Radiology and Lab Services. I understand that my Treating Doctor may have a professional radiology service review radiological images. My Treating Doctor may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physician and laboratories.

Equipment/supplies. I understand that my Treating Doctor may choose to prescribe additional supplies or equipment for my aftercare use and that these services are billed separately by the medical company.

Personal Effects. I release NovaMed Surgery Center of Chicago NorthShore from any responsibility for loss or damage to money, jewelry, or other personal effects that I bring into NovaMed Surgery Center of Chicago NorthShore .

I acknowledge that I have received the following items prior to the procedure:

- Patient Rights and Responsibilities
- The surgery center's policy about advanced directives.
- Physician ownership information.
- Voices grievances regarding care.
- Patient's Privacy

I CERTIFY that I have read and fully understand the above information that the procedure has been fully explained by my Treating Doctor, and I authorize and consent to the performance of the procedure.

Patient's Signature	Printed Name	Date & Time
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If patient's personal representative, state relationship and authority:

Representative's Signature	Relationship	Printed Name	Date & Time
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Witness' Signature	Printed Name	Date & Time
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