PROLIANCE SURGEONS®

Day of Surgery Facility Consent

I consent to care and treatment at this facility provided by my surgeon and assistants and/or the staff as may be deemed appropriate during my stay.

1. I am aware of my physician's ownership, if any, in Proliance Surgeons, Inc., P.S. and this surgery center and I am aware that I can choose to have my surgery performed at another facility where my surgeon has privileges.
2. I understand that anesthesia services are provided by an independent anesthesia group which is not employed by Proliance Surgeons or the surgeons.
3. I have been given a copy of the "Patient Rights and Responsibilities."
4. I understand that every effort will be made to protect my privacy and maintain confidentiality as required by HIPAA.
5. I am aware that due to the nature of outpatient surgery and the general good health of the patients, the surgery center will initiate resuscitative and other stabilizing measures should an emergency event occur while at the facility. Also if necessary, I will be transferred to an acute facility that will order any additional care in accordance with my Advance Directive (if provided today).
6. I have not had anything to eat or drink since _____.
7. I have made arrangements for a responsible adult to drive me home and to provide care for 24 hours following my surgery. This person is _____ and the contact number for today is _____.
8. If the patient is a minor, a parent or guardian MUST remain in the facility at all times.
9. At times this facility may have observers in the operating room. They are under the supervision of the surgeon and the operating room staff. They will not take part in your surgery
10. I am aware of the potential risk of skin puncture or exposure to myself and staff members while a patient at this facility and give my consent for blood tests (i.e. HIV and hepatitis) in the event such an exposure occurs.
11. I will contact my surgeon if any unusual bleeding, swelling, extreme pain or respiratory problems occur after my discharge.

_____ _____

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE | RELATIONSHIP OF LEGALLY RESPONSIBLE PERSON TO PATIENT

Date: **Time:**

Witness:_____ **Physician:**_____

Date: **Time:** **Date:** **Time:**