

# ENT Surgery Center of Atlanta LLC

5673 Peachtree Dunwoody Road, Suite 945 • Atlanta, GA 30342

## INFORMED CONSENT TO TREAT AND DISCLOSE INFORMATION

### To Our Patient:

You have the right as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be performed so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby consent to the performance of operations and procedures in addition to or different from those now planned whether or not arising from presently foreseen conditions, which the doctor named below or his associates or assistants may consider necessary or advisable during the operation or procedure.

I voluntarily request Dr. \_\_\_\_\_ as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition. I understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I voluntarily consent and authorize those procedures:

### I understand that:

- ◆ The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Procedures.
- ◆ **Physicians rendering services to me are owners of ENT Surgery Center, LLC.**

### (Initials)

- \_\_\_\_\_ I  (do)  (do not) consent to the transfusion of blood, blood components as deemed necessary.
- \_\_\_\_\_ I  (do)  (do not) hereby consent to the withdrawal of a blood sample from my body in the event that an employee or physician has had an accidental needle puncture or mucous membrane exposure to my blood or body fluid. I also understand that if an accidental contact does occur, that any blood drawn will be tested and handled in a manner that protects my privacy and identity. No results of any tests done on my blood will be released or shown to any unauthorized person without my written authorization.
- I  (do)  (do not) understand that I am scheduled to go home after my surgery and I must have a responsible adult drive me home and stay with me as advised by my physician.
- \_\_\_\_\_ I understand the surgery is intended to be performed on an outpatient basis. I consent to my transfer to a hospital or other facility should my physician(s) deem it advisable or necessary.
- The nature, purpose, and possible complications of the procedure and medical services described above; risks and benefits reasonably expected; and the alternative methods of treatment have been explained to me by the physician; and I understand the explanation I have received.
- \_\_\_\_\_ I understand the Surgery Center is not responsible or liable for the loss of or damage to any article of value that I brought to the center.
- \_\_\_\_\_ Because of the possible adverse effects of some medications on an unborn fetus, it is important to know if the patient is pregnant. Therefore, I certify that to the best of my knowledge I am not (the patient is not) pregnant.

In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated in the Surgery Center's price list (known as the "Charge Master") effective on the date of service, which rates are hereby expressly incorporated by reference as the price term of this Agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or the charge is listed as zero. In the event that the Surgery Center has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to herein, the undersigned agrees to the attorney's fees and collection expenses incurred by the Surgery Center.

An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Surgery Center. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

We may use or disclose information about you to bill or receive payment for medical treatment or services provided to you. These disclosures include releasing information:

- (1) to your health plan to obtain prior approval or to determine whether your plan will cover the treatment or services; or
- (2) to individuals or entities involved in collecting amounts owed to us.

Some or all of the health care professionals performing services in the Ambulatory Surgery Center are independent contractors and are not Surgery Center agents or employees. Independent contractors are responsible for their own actions and the Surgery Center shall not be liable for the acts or omissions of any such independent contractors.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Time \_\_\_\_\_  
 Patient

(if the patient is a minor or unable to sign, complete the following)

- Patient is a minor
- Patient is unable to sign because \_\_\_\_\_

Signature \_\_\_\_\_ Patient \_\_\_\_\_ Legally Designated Representative \_\_\_\_\_