

NEWPORT BEACH SURGERY CENTER

DATE	TIME IN	LAST NAME		FIRST NAME		M.I.	PAYMENT	C.I.
M/F	DOB	AGE	MSW	HOME PHONE		EMERGENCY CONTACT		PHONE
ADDRESS		STATE	CITY	COUNTY	STREET	ZIP		
PRIOR ADMIT	SSN	DRIVER LICENSE		OCCUPATION		WORK PHONE		
RELATION TO RESPONSIBLE PARTY		RESPONSIBLE PARTY SSN		RESPONSIBLE PARTY EMPLOYER		RESPONSIBLE PARTY PHONE		
PRIMARY INS. CO. NAME/NAME OF INSURED				SECONDARY INS. CO. NAME/NAME OF INSURED				
I.D. #/SSN	GROUP #		AUTHORIZATION		I.D. #/SSN	GROUP #		AUTHORIZATION
INSURED'S EMPLOYER AND PHONE				INSURED'S EMPLOYER AND PHONE				
SURGEON			DOI	CLAIM #		ATTENTION		
DIAGNOSIS								
PROPOSED SURGERY (LINE 1)								
PROPOSED SURGERY (LINE 2)								

DO NOT COMPLETE

ORIGINAL CONSENTS TO BE SIGNED UPON ADMISSION

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I understand that fees quoted are estimated and that actual charges cannot be determined until after surgery.

I hereby assign to and authorize payment directly to the facility named above (the "facility") of all benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility.

A photostatic copy of this agreement shall be considered effective and valid as the original.

I irrevocably agree that the facility may disclose, to the extent allowed by law, my medical and financial record to (a) any affiliate of the facility, specifically including Newport Beach Surgery Center and its employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, or any person or entity responsible for all or part of the facilities charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Health Care Financing Administration, any governmental or accrediting agency, or their agents or employees.

All facility charges are due and owing upon admission in consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payer. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the facility files for reimbursement from my insurer or other payor as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due.

Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

PATIENT DATE

GUARANTOR DATE

WITNESS DATE

PATIENT NAME	ACCOUNT RECORD	DATE
DO NOT COMPLETE		
PROCEDURE (LINE 1)		
PROCEDURE (LINE 2)		
ORIGINAL CONSENTS TO BE SIGNED UPON ADMISSION		
REFUSAL TO PERMIT BLOOD TRANSFUSION	DATE	SIGNATURE

INFORMED CONSENT TO OPERATION AND OTHER MEDICAL SERVICES INCLUDING TRANSFUSION(S)

1. The facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of the facility, but independent contractors and, therefore, are the patient's agents or servants. The facility provides nursing and support services and facilities; the facility does not provide medical physician care.
2. The procedure(s) listed to be performed and the advantages and disadvantages, risks and possible complications, as well as the alternatives have been explained to me by my physician. The doctor has satisfactorily answered my questions.
3. My consent is given with the understanding that any operation or procedure involves risks and hazards. The more common risks include; infection, bleeding with the need for blood transfusion, nerve injury, blood clots, heart attack, stroke, allergic reactions, damage to teeth or bridgework, and pneumonia. These risks can be serious and possibly fatal.
4. I authorize and direct the above-named surgeon to arrange for such additional services for me, as he or she may deem necessary or advisable, including, but not limited to, the administration and maintenance of anesthesia, and the performance of pathology and radiology services, to which I hereby consent. I accept financial responsibility for any additional services deemed necessary by my physician.
5. I authorize the pathologist or physician to use his or her discretion in disposing of any member, organ, implant, prosthetic, or other tissue removed from my person during the operation(s) or procedure(s).
6. The facility may participate in residency and other training programs for physicians, allied health professionals, and other providers of services. All care rendered by individuals in training will be supervised and reviewed, as appropriate, by appropriate personnel. I hereby consent to care and treatment from individuals in training and the review of my patient record by same.
7. In the event of a medical emergency, I **DO / DO NOT** (circle one) authorize the administration of transfusions of whole blood or blood products to me as my be deemed advisable by the anesthesiologist, my attending physician, and/or his associates or assistants. I understand that despite the exercise of due care, the transfusion of blood or blood products is always attended with the possibility of some ill effects such as the transmission of hepatitis, HIV, or certain other diseases, accidental immunization, or allergic reaction. I understand that in an emergency it may be necessary for the patient's well-being to use existing stocks of blood which may not include the most compatible blood types. (If the patient circles **DO NOT**, obtain the patient/guardian signature on the Refusal to Permit Blood Transfusion section.)
8. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV and hepatitis.
9. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me following my surgery/procedure(s). I acknowledge that I have been advised by facility personnel 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 surgery/procedure(s) or as directed by my physician.
10. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual procedure(s).
11. I consent to the use of video-taping or photography that may be used or scientific for teaching purposes, and to the review of my medical record for bona fide medical healthcare research, providing my name or identify is not revealed.
12. I release the facility from any responsibility for loss and/or damage to money, jewelry, or other valuables I brought into the facility.
13. I understand that if I am pregnant, or if there is any possibility I may be pregnant, I must inform the facility immediately since the scheduled procedure(s) could cause harm to my child or myself.
14. I am aware that my physician may have an ownership interest in the facility, and I acknowledge that I have a right to have the procedure(s) performed elsewhere.
15. I understand that in the rare event that hospitalization is required during or immediately after surgery, my physician will arrange for my transfer to a local hospital.
16. I have not eaten or taken fluids, not even water, since DATE _____ TIME _____ AM / PM, except for a sip of water taken with medication as instructed by my physician.
17. My signature below constitutes my acknowledgement that: (1) I have read or have had read to me the foregoing, and agree to it; (2) the procedure(s) has been adequately explained by my physician; (3) I authorize and consent to the performance of the procedure(s) and any additional procedure(s) deemed advisable by my physician in his or her professional judgment; (4) I authorize and consent to the administration of anesthesia for the said procedure(s).
18. If I am not the patient, I represent that I have the authority of the patient, who, because of age or other legal disability, is unable to consent to the matters above, (a) I have full right to consent to the matters above, and I consent to same, (b) I hereby indemnify and hold harmless the facility, its employees, agents, medical staff, partners and affiliates from any cost of liability arising out of my lack of adequate authority to give this consent.

DATE _____ TIME _____ PATIENT'S SIGNATURE _____

DATE _____ TIME _____ WITNESS TO SIGNATURE _____

If patient is a minor or unable to sign, complete the following:
 Patient is a minor Patient is unable to sign because: _____

DATE _____ TIME _____ SIGNATURE _____

RELATIONSHIP _____

DATE _____ TIME _____ WITNESS TO SIGNATURE _____

PATIENT NAME	ACCOUNT RECORD	DATE
DO NOT COMPLETE		
ORIGINAL CONSENTS TO BE SIGNED UPON ADMISSION		
PROCEDURE (LINE 1)		
PROCEDURE (LINE 2)		
REFERRING PHYSICIAN	STREET ADDRESS	CITY, STATE, ZIP

REQUEST FOR ADMINISTRATION OF ANESTHESIA

I Understand that it will be necessary to be placed under anesthesia in order to perform the above-described operation, and I consent to the use of anesthesia as deemed necessary and appropriate by my anesthesiologist, surgeon and nurse anesthetist. Anesthesia involves risk in addition to the risks of the surgical procedure itself. These risks include, but are not limited to, adverse drug reactions brain damage, death, nerve injury, damage to teeth or dental work, damage to vocal cords, respiratory problems, minor pain and discomfort, damage to arteries or veins, headaches, backache, or worsening pre-existing disease(s). The purpose, necessity, and risk of anesthesia have been explained to my satisfaction by a physician and there has been sufficient opportunity to discuss the proposed treatment and associated risks

I DECLARE AND REPRESENT THAT I HAVE READ THE ABOVE AND UNDERSTAND IT IS TRUE. No guaranty or warranty has been made to the result of the anesthetic procedures.

DATE _____ TIME _____ PATIENT/AUTHORIZED AUTHORITY _____

DATE _____ TIME _____ WITNESS TO SIGNATURE _____

ADVANCED DIRECTIVES/LIVING WILL/HEALTH CARE PROXY

Under federal and state law, you or your representative have the legal right to make informed decisions regarding your care. It is our policy, regardless of the contents of any advanced directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at Newport Beach Surgery Center we will initiate resuscitation or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power of attorney.

I understand I have the right to make choices regarding life-sustaining treatment (including resuscitative measures).

- Yes, I have provided the facility with a copy of my Advanced Directive/Living Will/Health Care Proxy. The facility has explained to me their policy regarding the honoring of this document and I agree to proceed with the proposed procedure as scheduled.
- Yes, I have executed an Advanced Directive; however, I have not provided one to the facility.
- No, I have not executed an Advanced Directive.
- I wish to have information on how I can obtain an Advanced Directive. Information received _____ (Initial).

DATE _____ TIME _____ PATIENT/AUTHORIZED AUTHORITY _____

REFUSAL TO PERMIT BLOOD TRANSFUSION

Date: _____ Hour _____ A.M. / P.M.

I request that no blood or blood derivatives be administered to _____ during this hospitalization, notwithstanding that such treatment may be deemed necessary in the opinion of the attending physician or his/her assistants to preserve life, or promote recovery. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatsoever for unfavorable reactions or any unforward results due to my refusal to permit the use of blood or its derivatives, and I fully understand the possible consequences of such refusal on my part.

When a patient is a minor or incompetent to give consent:

(Signature of Patient)

(Signature of person authorized to consent for Patient)

(Signature of Patient's Husband or Wife)

(Relationship to Patient)

(Witness)