CONSENT TO ROUTINE PROCEDURES, TREATMENTS AND ACKNOWLEDGEMENTS

By reading and signing this document, the undersigned patient (or authorized patient representative) consents to treatment (including routine diagnostic procedures; any appropriate emergency, out-patient and/or in-patient hospital care; any medical treatment ordered by the physician(s) responsible for such care) at HENRY MEDICAL CENTER ("the Medical Center") by individuals assigned to my care, and acknowledges the following:

(Please cross out and initial paragraphs which do not apply or for which consent is not granted.)

1. **ALL PHYSICIANS ARE INDEPENDENT PROFESSIONALS: Some or all of the healthcare professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors.** I understand that I have the right to select any physician on the medical staff, if he/she agrees to accept me as a patient. In the event of an emergency, in the event certain specialized services are required, or in the event I have not designated a physician, I consent to treatment by the applicable physician on call. This consent also extends to any professionals consulted or referred by my physician.
2. **PERSONAL VALUABLES:** The Medical Center provides facilities for safekeeping of valuables that I specifically request that the facility maintain. The Medical Center assumes no responsibility for, and I hereby release the Medical Center from loss or damage to any clothing, watch, jewelry, dentures, corrective lenses, personal appliances or other valuables which I keep in my possession or that may be brought to me in the Medical Center.
3. **AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD (3RD) PARTY PAYMENTS:** I hereby expressly authorize the Medical Center and all professionals providing for my care to release information to any insurance company, health plan, or other entity (3rd party payor) who may be responsible for paying for my care, including, but not limited to: ______________. I authorize and direct all 3rd party payers (including any specifically named above) to pay all benefits due for such care directly to the Medical Center and all professionals providing for such care, and I hereby assign such sums to them. I understand that this authorization and assignment shall remain valid unless I provide a written notice of revocation to the Medical Center and the 3rd party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or changes incurred before such revocation.
4. **GUARANTEE OF PAYMENT:** In return for services to be provided by the Medical Center, the undersigned specifically promises to pay and guarantees the payment of all charges for services rendered to the patient or for benefit of the patient by the Medical Center. Such payments are due and payable upon the patient's dismissal; however, the Medical Center may elect to accept assignment of benefits from any 3rd party payor, as it deems advisable.
5. **AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS:** I authorize and release the Medical Center and all professionals providing for my care to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be appropriate in their care of me. Additionally, images may be used for educational purposes. Patient confidentiality will be maintained.
6. **NO GUARANTEE OF RESULTS:** The Medical Center and the physicians cannot guarantee any specific result(s) of any examination, treatment or medical care. I understand that the physician(s) providing for my care may provide specific informed consent for certain treatment(s) or procedure(s). I release the Medical Center from any liability for any accident or injury that is not directly caused by the negligence of the Medical Center or its employees.
7. During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals ("healthcare professionals").

While routinely performed without incident, there may be material risks associated with each of these procedures. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures. I also understand that various healthcare professionals may have differing opinions as to what constitutes material risks and alternative procedures.

If I have any questions or concerns regarding these procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional Informed Consent documents.

The procedures may include the following;

Needle Sticks, such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of procedures include, but are not limited to, nerve damage, blood clots, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may or may not be less effective or not effective) or refusal of treatment.

Physical tests, assessments and treatments such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks with these types of procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified procedures and/or refusal of treatment, no practical alternatives exist.

Administration of Medications whether orally, rectally, topically (on the skin), injected into my body or through my eye, ear or nose. The material risks associated with these types of procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage, nerve damage, blood clots, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

Drawing Blood, Bodily Fluids or Tissue Samples such as that done for laboratory testing and analysis. The material risks associated with this type of procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, blood clots, bruising, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

Insertion of Internal Tubes such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, perforation of tissue, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

I understand that:

The healthcare professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; and

By signing this form:

I have read and understand this consent to treatment and acknowledgement.

A copy of this document may be utilized the same as the original.

I certify that the information provided by me on this form is complete and correct, including the information given by me in applying for payment under the Title XVIII of the Social Security Act.

I consent to healthcare professionals performing procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and

I acknowledge that I have been informed in general terms of the nature and purpose of the procedures; the material risks of the procedures; and practical alternatives to the procedures.

Signed:____________________________ WITNESS

____________________________ PATIENT/PARENT/GUARDIAN/GUARANTOR

If signed by other than patient, please indicate relationship:

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__________________ DATE

If signed by other than patient, please indicate reason:

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