



YOUR AMBULATORY SURGERY
CENTER IN WILMINGTON, DE

Conditions of outpatient admission

Please read each section carefully and then sign and date.

CONSENT TO RENDERING MEDICAL SERVICES/RELEASE OF INFORMATION AUTHORIZATION: RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY/BENEFIT ASSIGNMENT INFORMATION: PATIENT BILL OF RIGHTS & RESPONSIBILITIES/PATIENT INSTRUCTION SHEET

1. I the below named patient hereby authorize the below-named surgeon and/or his/her associates or assistants of his/her choice to perform operation indicated on the operative consent and/or such operations or any other therapeutic procedure upon me they may deem necessary or advisable. The necessity for the operation and the potential risks of the operation have been explained to me by my physician and no warranty or guarantee has been made as to the result or cure.
2. I hereby authorize the below-named surgeon and/or his/her associates or assistants to provide such additional services for me as he/she or they may deem necessary or advisable including procedures different from those now contemplated, and including but not limited to the administration and maintenance of anesthesia, nursing services, radiological and pathological services, and photography, videotaping and recordings of the operation for medical or educational purposes. I understand that in certain circumstances it may be necessary for a Healthcare Industry Representative to be present in the operating room to consult with the operative team.
3. I hereby authorize the below named surgeon to use his/her discretion in the retention, preservation or disposal of my severed tissue or member, except: _____
4. I hereby authorize all doctors, pharmacists, hospitals, the Wills Surgery Center of Wilmington or other institutions rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered (including copies of my records). A photostatic copy of this authorization shall be considered as effective and valid as the original.
5. I have reviewed a copy of the Patient Bill of Rights/Patient Responsibilities and understand my rights as stated.
6. I understand that the surgical and/or diagnostic procedure to be performed on me at the Facility will be done on an outpatient basis and that the Facility does not provide 24-hour patient care. If my attending practitioner, or any other duly qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the Facility to a hospital or other health care facility, I consent and authorize the employees and the Facility to arrange for and effect the transfer. I also authorize the hospital/treatment facility to which I am transferred to release treatment information , including the discharge summary, to the Surgery Center.
7. I authorize the Wills Surgery Center of Wilmington to release information , including any record, bills for services rendered, opinions, reports, x-rays in my medical chart, with respect to the treatment of the above-referenced patient , including any confidential HIV-related information, to any third-party who may be responsible for the payment or inquiry of my account, any alternative care-giver, and any accrediting review agencies as may be necessary.
8. I understand , I am financially responsible to the Wills Surgery Center of Wilmington for any charges incurred by the below named patient and promise to pay promptly the Wills Surgery Center of Wilmington the amount of such charges which are not paid by any insurance carrier for any reason. I agree that in the event my account should become delinquent, I will pay all reasonable attorney fees, court costs and other expenses pertaining to the collection of such account whether or not a law suit is commenced in connection with such collection efforts.
9. I was given an instruction sheet including information necessary to facilitate my preoperative , intraoperative and postoperative care. I understand and agree to abide by the instructions contained in the sheet.
10. I understand that any Advance Directive I may have will not be honored at the Wills Surgery Center of Wilmington as this is an outpatient surgery center and all measures necessary for resuscitation will be executed at this center.

Signed at the American Surgery Center at _____ a.m./p.m. on _____ 20_____.

Patient/Legal Guardian Signature

Witness Signature

If Financial Responsible/Insured person is other than Patient/Legal Guardian please sign below:

Financial Responsible/Insured Person's Signature

Witness Signature

PATIENT LABEL