DISCLOSURE & CONSENT
Medical, Surgical, and Diagnostic Procedures

Patient Sticker

PATIENT: _____

TO THE PATIENT: You have the right to be informed about your condition and recommended surgical, medical, or diagnostic procedures. You may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

I give my consent to Dr. _____as my physician, and such associates, technical assistants and other assistants as they may deem necessary, to treat my condition by performing the following operation(s) or procedure(s):

I understand that my physician may discover other or different conditions which may require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgement.

I understand that no warranty or guarantee has been made to me as to the result or cure.

I consent to the disposal by **Monterey Peninsula Surgical Center** (MPSC) of any tissues or parts, which may be removed.

Exceptions:_____

There are risks and hazards related to the performance of surgical, medical and/or diagnostic procedures such as infection, blood clots in veins and lungs, hemorrhage, allergic reactions, death, paralysis, stroke, etc. There are also risks and hazards of continuing my present condition without treatment. My physician has discussed the appropriateness of the proposed procedure(s), explained the risks, and alternative treatment techniques, and answered all my questions.

_____I do (do not) consent to the use of blood and blood products as deemed necessary.

_____I do (do not) consent to the photographing, X-ray imaging, ultrasound imaging, scanning, videotaping, or other imaging of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, providing my identity is not revealed by descriptive texts accompanying the pictures.

_____I do (do not) agree to the possible presence of a scientific observer (such as an equipment representative, physical therapist or other healthcare professional, medical student, and/or quality assurance surveyor) in the operating room during my surgical care should my surgeon make such a request. I understand that said observer is not in any way associated with MPSC. I hereby release MPSC, its agents, assigns and successors from any and all liability, which may result from the presence of a scientific observer in the operating room.

I understand I will be transferred, by ambulance, to an acute care facility, if it is deemed necessary.

I understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or death. Other risks and hazards, which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth, or eyes.

I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved. I believe that I have sufficient information to give this informed consent.

I have been informed that my physician may have a financial interest in the facility in which my surgery is to be performed and that I may choose any facility, such as Community Hospital of the Monterey Peninsula, for the purpose of obtaining the services recommended or requested.

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate their decisions.

MPSC respects these rights, however: **It is the policy of Center that our personnel will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital in the event of deterioration.** At the acute care hospital further treatment or withdrawal of treatment measures already begun may be ordered in accordance with your wishes, Advance Directives, or Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney. If you DO NOT agree to this policy, MPSC personnel will assist you to reschedule the procedure at another facility. Please check the appropriate box in answer to this question. **Have you executed an Advance Health Care Directive, a Living Will, and/or a Power of Attorney that authorizes someone to make health care decisions for you?**

☐ YES, I have an Advance Directive, Living Will and/or Health Care Power of Attorney.

☐ I have ☐ have not provided a copy of my Advanced Directive to be placed in my medical record

☐ NO, I do not have an Advance Directive, Living Will, and/or Health Care Power of Attorney.

☐ I would like to have information on Advance Directives.

☐ Gave to Patient _____

☐ I have received the MPSC Patient Brochure with information on Patient Rights and Responsibilities, Physician Ownership, Advance Directives and Grievance Policy.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

Date:_____ Time_____

Patient Signature:_____

If patient is a minor, complete the following:

Other Legally Responsible Party:_____

Relationship to Patient_____

Verification of Patient Signature Witness:_____