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PEAKONE
SURGERY CENTER

FACILITY ACKNOWLEDGEMENT

1. I CONSENT TO TREATMENT at **Peak One Surgery Center** (This is an Ambulatory Surgery)
   I, the undersigned, herby consent to and authorize all diagnostic and therapeutic treatment performed at Peak One Surgery Center considered necessary or advisable in the judgment of the attending physician. Any tissue or parts removed may be preserved and examined or disposed of by Peak One Surgery Center in accordance with accustomed practice of the facility. I understand that there will be a cost associated with these tests.
   I understand that my physician may order a blood test drawn from me for (including but not limited to) HIV (AIDS) and hepatitis antibodies. I consent to withdrawal only if an employee or physician has had an accidental exposure to my body fluids. I understand that I could obtain the results of these tests from my physician who can explain them. I authorize release of data necessary to process the testing and insurance claim and I understand there will be no cost to me for this test.
   PHOTOGRAPHS/VIDEO TAPES: I consent for photographing or video recording deemed necessary by my surgeon. I understand these photographs/video recording are the property of my surgeon.
   RELEASE OF IMFORMATION: A photocopy of this assignment is to be considered as valid as an original and revocable by me only in writing. I hereby authorize said assignees to release all information to secure payment. I authorize the center and all clinical providers who have provided care to me, along with any billing services, collection agencies, attorneys or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.

2. I have read and will comply with the Instructions.

3. I certify that I have had no solid food as directed by nurse. Water and medications as instructed by nurse or physician.

4. **I have made arrangements for a responsible adult to accompany me the day of the procedure, drive me home and to provide my procedure home care.**

5. I will contact my doctor if any unusual bleeding, swelling, extreme pain or respiratory problems occur after my discharge.

6. I understand that for 24 hours following anesthesia and conscious sedation I must not drive, operate equipment, or make any legally binding decisions (legally binding documents are null and void if you are under the influence of anesthesia).

7. I understand that if a condition arises during my procedure or recovery and the doctor feels that admission to the hospital is required, I will be admitted to Summit Medical Center.

8. **I understand that my physician may have a financial interest in this Surgery Center**.

9. For the purpose of medical advancement, I consent to having observers in the procedure room, under the supervision of the physician and pain center staff.

10. **I have read and understand my rights and responsibilities as a patient of the Peak One Surgery Center.**

11. **I hereby acknowledge that I received the Peak One Surgery Center's HIPAA Notice of Privacy Practices.**

Page 1 - Patient/Legal guardian initials: _____

Patient Label .

12. For my transportation home contact _____ at_____.

13. I have received information in my language prior to my surgery. I understand and have been given an opportunity to ask questions about:

_____ ***Advance Directives*** _____ *I have requested and received information about Advance Directives*

_____ *I have provided a copy of my Advance Directives to the Center*

Peak One Surgery respects your right to participate in decision regarding your health care. Our policy is that we will use all measures possible to sustain life.
For additional information: www.caringifo.org/stateaddownload or 1-800-658-8898

_____ ***My Rights and Responsibilities as a patient***

_____ ***My physician's part ownership in the Surgery Center***

_____ _____
Patient Signature or Legal Guardian Date

_____
Witness

Patient Label .