Please initial each.

________ I have read, received a copy and fully understand ***Medical Village Surgery Center Notice of Information Practice.*** I understand that ***Medical Village Surgery Center*** may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services providing and any administrative operation related to treatment or payment, I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations is I notify the practice. I also understand that ***Medical Village Surgery Center*** will consider request on a case-by-case basis, but does not have to agree to request for restriction. I hereby consent to the use and disclosure of my personal health information for purposes as noted in ***Medical Village Surgery Center*** Notice of Information Practice, i understand that i retain the right to revoke this consent by notifying the practice in writing at any time.

________ I have read and received a copy and fully understand ***Medical Village Surgery Center*** Patient Right and Responsibilities,

________ have read and received a copy on the Physician Ownership List for ***Medical Village Surgery Center.*** i understand a list of alternative facilities will be provided to me at my request. By signing I am confirming that I have been made aware of the Physician's Ownership interest in ***Medical Village Surgery Center.*** Based on this knowledge, I have agreed to have my surgery at ***Medical Village Surgery Center.***

________ I have read and received a copy of the Admissions Disclaimer that contains information regarding Professional or Ancillary Services that I may be billed for separately from ***MVSC.***

Please initial one of the following statements in regards to Advance Directives/Living Will.
________ Yes, i have provided ***Medical Village Surgery Center*** with a copy of my Advance Directive/Living Will. The facility has explained to me their policy that if an adverse event occurs during my stay, based on reason of conscience, all reasonable efforts will be taken to revive me, including resuscitative or other stabilizing measure and f agree to proceed with the proposed procedure as scheduled.

________ I do have an Advanced Directive/Living Will, but i have not provided the facility with a copy. The facility has explained to me their policy that if an adverse event occurs during my stay, based on reason of conscience, all reasonable efforts will be taken to revive me, including resuscitative or other stabilizing measures and I agree to proceed with the proposed procedure as scheduled.

________ I do not have an Advanced Directive/Living Will. The facility has explained to me their policy that is an adverse event occurs during my stay, based on reason of conscience, all reasonable efforts will be taken to revive me, including resuscitative or other stabilizing measure and I agree to proceed with the proposed procedure as scheduled.

Patient Name (please print)	Witness
Patient Signature	Date
Date	

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUTYOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

MEDICAL VILLAGE SURGERY CENTER'S LEGAL DUTY

Medical Village Surgery Center is required by law to protect the privacy of your personal health information, provide this notice about our information practices and fellow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Medical Village Surgery Center uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administration activities and evaluating the quality of care that we provide. For example, ***Medical Village Surgery Center*** may use your personal health information to contact you to provide appointment reminders or other health related information that could be of interest to you.

Medical Village Surgery Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situations, ***Medical Village Surgery Center's*** policy is to obtain your written authorization before disclosing your personal health information. It you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time, ***Medical Village Surgery Center*** may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. ***Medical Village Surgery Center*** will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them, unless disclosure is for a purpose other than treatment, and you have paid in full for the service. You have the right to be notified if a breach in the security of your Protected Health Information (PHI) occurs.

CONCERNS AND COMPLAINTS

If you are concerned that ***Medical Village Surgery Center*** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send or call in a complaint to the US. Department of Health and Human ‘ Services 1200 Independence Avenue SW / Washington, DC. 20201. For further information on ***Medical Village Surgery Center's*** health information practices, or if you have a complaint, please contact: ***Privacy Officer - Medical Village Surgery Center / 2507 Medical Row, Ste 101, Grand Prairie, TX 75031 / (972) 647 8520.***

PATIENT INFORMATION CONSENT FORM

I have read and fully understand **MEDICALVILLAGE SURGERY CENTER'S** Notice of Information Practices. I understand that **MEDICAL VILLAGE SURGERY CENTER** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations it I notify the practice. I also understand that **MEDICAL VILLAGE SURGERY CENTER** will consider requests on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health-information for purposes as noted in **MEDICAL VILLAGE SURGERY CENTER'S** Notice of information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Important Message to All Patients - Admissions Disclaimer

Professional/Ancillary Services

Individuals providing Professional or Ancillary Services generally **DO NOT** work for Medical Village Surgery Center.

Examples include:

Physician Fees
Laboratory Services
Anesthesiologists
Pathologists

Charges for these services are billed separately from Medical Village Surgery Center. As a result of the separate billing practices, we cannot ensure Professional/Ancillary services are contracted with your insurance company's "provider network." If an out of network Professional provides services, it is possible that you will be responsible for those expenses.

Please let us know it you have any questions. Thank you

Medical Village
SURGERY CENTER

DISCLOSURE AND CONSENT - ANESTHESIA and/or PERIOPERATIVE PAIN MANAGEMENT (ANALGESIA)

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesia after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the anesthesia/analgesia.*

I voluntarily request that anesthesia and/or perieperative pain management care (analgesia) as indicated below be administered to me (the patient). I understand it will be administered by an anesthesia provider and/or the operating practitioner, and such other health care providers as necessary. Perioperative means the period shortly before, during and shortly after the procedure.

I understand that anesthesia/analgesia involves additional risks and hazards but I request the use of anesthesia/analgesia for the relief and protection from pain or anxiety during the planned and additional procedures. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me.

I understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest, brain damage, paralysis, or death.

I also understand that other complications may occur. Those complications include but are not limited to:

Check planned anesthesia/analgesia method(s) and have the patient/other legally responsible person initial.

☐_____ GENERAL ANESTHESIA — injury to vocal cords; teeth, lips, eyes; awareness during the procedure; memory dysfunction/memory loss; permanent organ damage; brain damage.

☐_____ REGIONAL BLOCK ANESTHESIA/ANALGESIA — nerve damage; persistent pain; bleeding/hematoma; infection; medical necessity to convert to general anesthesia; brain damage.

☐_____ SPINAL ANESTHESIA/ANALGESIA — nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoms; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐_____ EPIDURAL ANESTHESINANALGESIA — nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐_____ DEEP SEDATION — memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

☐_____ MODERATE SEDATION — memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

I understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

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

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

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required)

X____

Please Print Name: X____

DATE:_____________________________ **TIME:** _____________________________ **A.M./P.M.**

WITNESS (signature required):

X____

DATE:_____________________________ **TIME:** _____________________________ **A.M./P.M.**

I have explained the risks, benefits, alternatives and potential complications to the patient.

X
Physician Signature

DATE:_____________________________ **TIME:** _____________________________ **A.M./P.M.**

Medical Village
SURGERY CENTER

DISCLOSURE AND CONSENT

Medical and Surgical Procedures

TO THE PATIENT:You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to procedure.

I (we) voluntarily request____________________as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as:

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures:

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

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

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

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:

____

____

____

____

____

____

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand the certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even 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 (we) understand that other risks and hazards resulting from spinal and epidural anesthetics including headache and chronic pain.

I (we) have been given an 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, and I (we) be that
I (we) have sufficient information to give this informed consent.

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

PATIENT/OR THE LEGALLY RESPONSIBLE PERSON (signature required)

____

DATE:______________________________ **TIME:** ______________________________ **A.M./P.M.**

WITNESS:

____
Signature

____
Name (Print)

Medical Village Surgery Center
2507 Medical Row, Ste 101
Grand Prairie, TX 75031

I have explained the risks, benefits, alternatives and potential complications to the patient.

PHYSICIAN:

____

DATE:______________________________ **TIME:** ______________________________ **A.M./P.M.**