[redacted]

Georgetown University Hospital
MedStar Health

Consent for Treatment, Releases, Acknowledgement and Financial Agreement

[redacted]

(7/31/09) GUH07024000

By my signature on the front side of this form, I agree that I:

1. **GENERAL CONSENT FOR TREATMENT.** Voluntarily consent to and authorize such care and treatments, including but not limited to, physical or mental examination, diagnostic tests, medical procedures and medication ("treatments') by employees and authorized agents of Georgetown University Hospital ("Hospital") as may be considered necessary or advisable in their professional judgment, and may include the drawing and testing for HIV (The virus that causes AIDS) and other blood borne diseases. I further acknowledge that no guarantees have been made regarding the effect of such treatments on any medical condition.

2. **RIGHT TO REFUSE TREATMENTS.** Understand that I have the right to make informed decisions regarding all care and treatments, and that I should ask my health care professionals to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments that I do not want.

3. **ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY.** Authorize and assign all claims for and payments of any insurance benefits, workers' compensation benefits, government agency and disability benefits, directly to the hospital for services rendered. I further assign the proceeds of any settlements, judgments ore verdicts from third party liability claims for injuries treated by the hospital to the hospital in an amount equal to the outstanding balance of all charges due and owing. I agree that any excess payments may be applied by hospital party, or guarantor of payment for patient. I agree to be responsible for all charges not covered by the patient's insurance coverage or other claims. I further agree that in the event payment is not made in full for all hospital charges, that to the extent permitted by applicable law, I shall pay all hospital costs of collection including reasonable attorney's fees and/or collection agency fees.

4. **PROPERTY RELEASE.** Release the hospital from any responsibility for valuables, money, personal or other possessions which are not properly deposited by me with the hospital depository and that in any event the hospital's maximum liability shall be $500.00 (five hundred dollars.)

5. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRATICES.** Acknowledge that I have received or decline the MedStar Health Notice of Privacy Practices and acknowledge that this notice is available for me to keep.

FOR GEORGETOWN UNIVERSITY HOSPITAL USE ONLY

Patient Signature / Acknowledgement of receipt of Notice of Privacy Practices not obtained because:

- ☐ Emergency Patient
- ☐ Patient / Patient Representative declined to acknowledge receipt
- ☐ Patient / Patient Representative unable / unwilling to acknowledge receipt _____
  GUH Representative

Any questions regarding this consent are to be directed to the charge nurse or attending physician on duty.

[redacted] _____ Date 9/24/10

Signature of Patient or Responsible Party

_____ _____

Printed Name of Patient or Responsible Party | Relationship to Patient

[redacted] [redacted] [redacted]

Reg Date/Time: 09/24/2010 18:40 Room:

MedStar Georgetown University Hospital

[redacted]

PATIENT LABEL

CONSENT FOR SURGERY, ANESTHETICS, AND OTHER MEDICAL SERVICES

1. I hereby authorize Dr. [redacted] (the primary surgeon/practitioner) and whomever he/she may designate as his/her assistants to perform upon [redacted] (patient name) the following surgical, medical or diagnostic procedure(s): (physician to state the specific procedure to be performed

IMAGE GUIDED TIB FIBULAR PLACMT WITH SEDATION.

2. I acknowledge that my physician has discussed with me the proposed care, treatment and services. I have been advised of the potential benefits, risks, side effects and likelihood of achieving goal. I also have been advised of any potential problems that might occur during recuperation. I have been advised of reasonable alternatives to proposed care, treatment, services and risks, benefits and side effects related to the alternative treatment and the risk related to not receiving the proposed care, treatment and services. I understand that in the course of the procedure the physician may determine that procedures in addition or different from this procedure may be necessary to my well being and that it would not be practical to obtain further consent at the time. I therefore authorize the doctor to perform such procedures without further consultation with me.
3. I have been provided information that in certain circumstances information about my care, treatment and services may be disclosed as required by law or regulation. Certain circumstances may include mandatory reporting requirements to the Centers for Disease Control, health department or Food and Drug Administration.
4. I also consent to the administration of anesthetics by or under the direction of the physician that has been trained to perform the required local anesthetic or moderate or deep sedation. The physician has explained the risks, benefits, side effects, and alternatives of the intended anesthesia.
5. I acknowledge that other qualified professionals, such as physicians in training or health care industry representatives may participate in performing the test or operation under the oversight and supervision of the supervising physician. The decision to include these other qualifying professionals will be made at the time of the test or procedure by the supervising physician and will depend on the availability of personnel and level of expertise.
6. I acknowledge that MedStar Georgetown University Hospital is a teaching institution. For purposes of research, medical education or documentation of my medical condition in the medical record, I consent to the taking of photographs or films during the course of the procedure(s). I understand that my identity will not be revealed if the photographs or films are used for medical education or research, and in all instances patient confidentiality will be preserved. I understand that copies of the prints will be given to me if I ask for them.
7. I am aware that the practice of medicine and surgery is not an exact science, that there is no certainty that the desired benefits will [redacted] s or assurances have been made to me concerning the outcome.

[redacted] 7/26/18 0905 [redacted]

Date Time Relation to Patient

[redacted] 7/26/18 0905

Witness signature Date Time

☐ **OR SETTING DAY OF SURGERY:**

Procedure listed Above Re-Read and Confirmed: _____ PROCEDURE PHYSICIAN

Site Marked: ☐ Left ☐ Right ☑ N/A _____ PROCEDURE PHYSICIAN

Site Unmarkable: ☐ Left ☐ Right **Location/Description** _____

Patient Identity Confirmed: [redacted] & _____

CIRCULATING / PROCEDURE NURSE ANESTHESIA CARE PROVIDER

☑ **NON-OR SETTING CHECKLIST:**

Team Pause Date: 7/26/18 **Time:** 0905 **Signature & Title** _____

☑ **Patient receiving anticoagulation:** ☐ Yes ☐ No ☑ **Coagulation abnormalities addressed:** ☐ Yes ☐ No

☑ **Correct Patient Identity** ☑ **Agreement on Procedure to be Done**

☑ **Correct Site & Side Marked:** ☐ Left ☐ Right ☑ N/A

☑ **Correct Patient Position** ☐ **Availability of All Anticipated Equipment, Meds and/or Supplies**

☐ **Patient History Checked**

[redacted]