Consent to Surgical/Invasive Procedure

[redacted]

1. **AUTHORIZATION:** I authorize the performance on myself/the patient, [redacted]

   the following surgical/invasive procedure(s): Cardiac Catheterization with possible percutaneous coronary intervention

   I understand that the surgery/procedure will be performed under the direction, supervision and authority of the following physicians or medical practitioners or their associates: [redacted]

2. **SEDATION:** I have been advised that moderate sedation may be administered to perform the procedure and have been informed of the risks, benefits and alternatives. The risks or complications include but are not limited to nausea, vomiting, memory dysfunction/memory loss, depressed breathing, injury to blood vessels, increased awareness, anxiety or discomfort, and potential conversion to general anesthesia.
3. **OTHER QUALIFIED PRACTITIONERS:** I have been advised that the surgery/procedure(s) may be performed by other medical practitioners under the direct or indirect supervision of my/patient's physician/provider or associate. I understand that the qualified practitioners may include but are not limited to, residents, medical students, other clinical students, allied health professionals or assistants. I consent to these other qualified practitioners to perform important parts of the surgery/procedure(s) and I understand that they will only be performing those tasks within their individual skills/training.
4. **TECHNICAL ASSISTANCE:** I understand that physician/provider or associate may utilize the technical support of a vendor representative related to the use of medical device, procedural equipment or instrumentation.
5. **OBSERVATION:** I consent to the admittance of qualified observers for approved educational purposes as approved by the Advocate facility and the Attending Provider.
6. **NATURE OF PROCEDURE:** I have had an opportunity to discuss the surgery/procedure with my/the patient's physician/provider or associate. The nature of my condition, the nature and purpose of the surgery/procedure, including the failure to treat my condition, the risks and benefits, possible complications and adverse outcomes (including but not limited to severe disability or death) and any available, feasible treatment alternatives have been explained to me. I do hereby assume all risks involved and understand that no guarantee or assurance has been given to me by anyone as to the results that may be obtained.
7. **ADDITIONAL PROCEDURES:** I consent to the performance of surgery and/or procedures in addition to or different from those planned, whether or not arising from presently unforeseen conditions, which the above named physician/provider or associate may consider necessary or advisable in the course of the surgery or procedure including the use of additional medical practitioners as needed.
8. **BLOOD PRODUCTS:** I consent to the administration of whole blood or blood components. It has been explained to me that there is the possibility of ill effects including, but not limited to infection and other disease resulting from the administration of blood or blood components. I acknowledge and agree that neither the physician nor the Advocate facility provide any guarantee nor warranty with respect to the blood or blood components. ***If patients requests bloodless procedure obtain patient signature on Refusal of Blood Administration Form****
9. **TISSUE USE:** I authorize the preservation and use for scientific or teaching purposes, or otherwise dispose of, the tissues, body fluids, or body parts resulting from the procedure and treatment authorized above.
10. **PHOTOGRAPHY:** I understand that the Physician/Provider may need to take photographs, video and or audio recordings to document a medical condition, help with the diagnosis and/or treatment and/or assist with the surgery/procedure. I also understand that these images may be used for advancing education with my/the patient's identifiers not revealed.
11. **INDEPENDENT PHYSICIAN SERVICES: I acknowledge and fully understand that the physicians who provide medical services to me at the hospital/facility ARE NOT EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY, BUT RATHER ARE INDEPENDENT CONTRACTORS OR PRACTITIONERS. ONLY THOSE PHYSICIANS WHO HAVE EXPLICITLY AND CLEARLY IDENTIFIED THEMSELVES AS HOSPITAL/FACILITY EMPLOYEES ARE THE EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY. Non-employed physicians are independent practitioners WHO ARE PERMITTED TO USE THE HOSPITAL/ FACILITY TO RENDER MEDICAL CARE AND TREATMENT. Non-employed physicians include, but are not limited to, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology and other specialties. I have been told that the hospital/facility does not control the medical decisions made by the independent physicians. These independent physicians exercise their own medical judgment in treating me or otherwise providing professional services to me and are solely responsible for their care and treatment. I understand that I should ask my physician any questions I may have about**

his or her employment status. My decision to seek medical care at the hospital/facility is NOT BASED UPON ANY UNDERSTANDING, REPRESENTATION, ADVERTISEMENT, MEDIA CAMPAIGN, INFERENCE, PRESUMPTION, and OR RELIANCE THAT THE PHYSICIANS PROVIDING CARE AND TREATMENT TO ME ARE EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY.

Patient/Legal Representative Signature:
My signature below constitutes my acknowledgement and agreement that I have read and understand the Consent Form information, was given an opportunity to discuss this form and ask questions, and that all questions were answered to my satisfaction. I understand that this consent may be revoked by me any time before the surgery/procedure is performed.

DO NOT SIGN IF YOU HAVE ANY QUESTIONS

Date: 4/18/21 Time: 1533 Signed: X [redacted]
Patient/Legally Authorized Representative

Date: 4/18/21 Time: 1533 Signed: [redacted]
Witness Signature

Certificate of Interpretation:
I certify that I have interpreted the forgoing to signor hereof in the _____ language.

Date: _____ Time: _____ Interpreter Signature: _____

PHYSICIAN/PROVIDER SIGNATURE & INFORMED CONSENT AFFIRMATION:
My signature below affirms that prior to the time of the surgery/procedure that I have informed the patient or the patient's Legally Authorized Representative of the medical condition requiring surgical treatment and/or procedure. I have explained the nature and purposes of the treatment or procedure, the complications and consequences, the reasonable possible alternatives and consequence of not doing the procedure, and the potential risks and benefits of each. I have also given the opportunity to ask questions and have answered any such questions.

Date: 4/18/21 Time: 3:34p Signed: [redacted]

Does the Patient have No CPR Orders/Limitation of Emergency Treatment (LET) Orders? ☐ YES ☐ NO
If yes, see below for reaffirmation or suspension

Operating Room NO CPR Orders/Limitation of Emergency Treatment (LET) Orders
The patient or his/her Legally Authorized Representative has discussed with the physician indicated below whether the patient's NO CPR Orders/LET Orders should continue or be suspended during the planned surgery. The following has been decided:
(MARK ONE)

_____ The patient's NO CPR Orders/LET Orders will continue in the Operating Room and during the perioperative period.
_____ Cardiopulmonary Resuscitation (CPR) will be provided to the patient in the event of cardiac arrest and all other LET Orders will be suspended in the Operating Room and during the perioperative period until the NO CPR Orders/LET Orders are reinstated

Date: _____ Time: _____ Signed: _____
Patient/Legally Authorized Representative

Date: _____ Time: _____ Signed: _____
Witness Signature

Date: _____ Time: _____ Signed: _____
Physician Signature

Consent for Anesthesia Services

1. **AUTHORIZATION:** I authorize the provision of anesthesia services for myself/the patient, _____,

   related to the following surgical/invasive procedure(s):_____

   _____

   I understand that the Anesthesia services will be provided under the direction, supervision and authority of one of the following: Anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or a physician credentialed to provide anesthesia services. I understand that at the time of the procedure that the anesthesia services may be provided by an associate of the below named provider and have been informed of this prior to the initiation of the procedure.
   (Provider Name) _____

2. **OTHER QUALIFIED PRACTITIONERS:** I have been advised that anesthesia services may be performed by other medical practitioners under the direct or indirect supervision of the Anesthesia Provider or his/her associate. I understand that the qualified practitioners include but are not limited to residents, clinical students, allied health professionals or assistants and that they will only be performing those tasks within their individual skills/training.
3. **NATURE OF SERVICES:** I have had an opportunity to discuss the anesthesia services with the Anesthesia Provider and/or Associate. The nature of my condition, the nature and purpose of anesthesia services, the risks and benefits, any available, feasible treatment alternatives, possible complications and adverse outcomes including but not limited to severe disability or death has been explained to me. I do hereby assume all risks involved and understand that no guarantee or assurance has been given to me by anyone as to the results that may be obtained.
4. **PROVISION OF ANESTHESIA:**
   I consent to the anesthesia services as checked below and authorize its administration for the procedure. I understand that the anesthetic technique to be used is determined by many factors, including my/the patient physical condition, the type of procedure, anesthesia provider preference, and my/the patient expressed preferences. It has been explained that it may require insertion of monitoring lines and catheters to safely administer the anesthesia which can have complications to blood vessels. I understand that anesthesia involves additional risk and hazards including serious, but rare, complications of breathing & heart problems, drug reactions, nerve damage, cardiac arrest, brain damage, paralysis or death. I understand that changes in the anesthetic may be necessary as my/the patient's condition warrants and may have to be changed, possibly without explanation to me.

Planned Anesthesia	Other potential complications or risks include:
☐ General Anesthesia	Nausea; vomiting; injury to vocal cords, teeth, lips, eyes; awareness during procedure, memory dysfunction/memory loss; aspiration; permanent organ damage;
☐ Nerve Block	Nerve damage; persistent pain; bleeding/hematoma; infection; conversion to general anesthesia; incomplete analgesia, temporary motor weakness;
☐ Spinal	Nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; conversion to general anesthesia;
☐ Epidural	Nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; conversion to general anesthesia;
☐ Monitored Anesthesia Care (MAC)	Nausea; vomiting; memory dysfunction/memory loss; depressed breathing; increased awareness; anxiety or discomfort; conversion to general anesthesia;
☐ Deep Sedation	Nausea; vomiting; injury to vocal cords, teeth, lips, eyes; awareness during procedure, memory dysfunction/memory loss; aspiration; permanent organ damage; conversion to general anesthesia;
☐	

5. **PATIENT MEDICAL HISTORY:** I understand the importance in providing the anesthesia provider with a complete medical history, including the need to disclose any medications that I or the patient is taking, both prescription and over the counter. I also understand that any use of herbal remedies, alcohol or any type of illegal/recreational drug can result in serious drug interactions or complications and must be disclosed.

6. **INDEPENDENT PHYSICIAN SERVICES:** I acknowledge and fully understand that the physicians who provide medical services to me at the hospital/facility ARE NOT EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY, BUT RATHER ARE INDEPENDENT CONTRACTORS OR PRACTITIONERS. ONLY THOSE PHYSICIANS WHO HAVE EXPLICITLY AND CLEARLY IDENTIFIED THEMSELVES AS HOSPITAL/FACILITY EMPLOYEES ARE THE EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY. Non-employed physicians are independent practitioners WHO ARE PERMITTED TO USE THE HOSPITAL/ FACILITY TO RENDER MEDICAL CARE AND TREATMENT. Non-employed physicians include, but are not limited to, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology and other specialties. I have been told that the hospital/facility does not control the medical decisions made by the independent physicians. These independent physicians exercise their own medical judgment in treating me or otherwise providing professional services to me and are solely responsible for their care and treatment. I understand that I should ask my physician any questions I may have about his or her employment status. My decision to seek medical care at the hospital/facility is NOT BASED UPON ANY UNDERSTANDING, REPRESENTATION, ADVERTISEMENT, MEDIA CAMPAIGN, INFERENCE, PRESUMPTION, OR RELIANCE THAT THE PHYSICIANS PROVIDING CARE AND TREATMENT TO ME ARE EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY.

Patient/Legal Representative Signature:
My signature below constitutes my acknowledgement and agreement that I read and understand the Consent Form information, was given an opportunity to discuss this form and ask questions, that all questions were answered to my satisfaction, and I am satisfied I understand the form's contents and significance. I understand that this consent may be revoked by me any time before the anesthetic is given.

DO NOT SIGN IF YOU HAVE ANY QUESTIONS

Date: _____ Time: _____ Signed: _____
Patient/Legally Authorized Representative

Date: _____ Time: _____ Signed: _____
Witness Signature

Certificate of Interpretation:
I certify that I have interpreted the forgoing to signor hereof in the _____ language.

Date: _____ Time: _____ Interpreter Signature: _____

ANESTHESIA PROVIDER SIGNATURE & INFORMED CONSENT AFFIRMATION:
My signature below affirms that prior to the time of the procedure that I have informed the patient or the patient's Legally Authorized Representative, of the methods of anesthesia proposed. I have explained the nature and purposes of the anesthesia, the complications and consequences, the reasonable possible alternative anesthesia methods and the potential risks and benefits of each. In addition I have described the anesthetic to be used and indicated that an alternative form of anesthesia may be used if required by unexpected conditions arising before or during the procedure. I have also given the opportunity for the patient/authorized representative to ask questions and have answered any such questions.

Date: _____ Time: _____ Signed: _____

Advocate Health Care

[redacted]

HEALTH CARE CONSENT

1. TO TREAT: I, for myself (or the patient named below) and if applicable, any infant I deliver, hereby consent to such diagnostic procedures and medical treatment as necessary and appropriate for my condition or illness, which may include HIV testing, unless I specifically opt-out of the HIV testing by informing my treating provider that I decline such testing.The diagnostic procedures and medical treatment to be provided shall be determined by my physician(s) or other appropriate practitioners, as necessary or advisable at the time treatment is performed, and shall be provided at the hospital, by staff physicians on the hospital medical staff, nurses and other health care providers. I understand that healthcare providers in training, may, under the supervision of appropriate personnel, participate in my treatment.

2. COORDINATION OF CARE: I understand that Advocate Health Care is a clinically integrated health system that is comprised of multiple hospitals, medical groups, and other health care provider entities that all work together to provide high quality patient care and to ensure efficient coordination of patientcare. I understand that Advocate will store my patient health information in an Electronic Medical Record format and that my medical record, including but not limited to my diagnosis, treatment plan, prescription information, appointment schedule and lab and other diagnostic results (including HIV related information, genetic information, and behavioral health records), will be viewable by individuals who are members of my interdisciplinary care team across the entire Advocate Health Care system. The interdisciplinary care team is comprised of employees, contractors, agents, and medical staff members of Advocate Health Care, its affiliates and Advocate Medical Group, among others, who work together for admission, treatment, planning, coordinating care, discharge or governmentally mandated public health reporting purposes.

3. PHOTOGRAPHY: I understand that my provider may need to take photographs, video and/or audio recordings to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or help plan details of surgery. I understand that my provider or the hospital will retain the ownership rights to these photographs, videos and/or audio recordings. I also understand that these images may be used for advancing education provided the patient identifiers are not revealed.

4. HOME HEALTH CHOICE: I understand that I have the freedom to choose and the right to select my home care provider for care I might need. I am aware that, in order to improve continuity and quality of care, the hospital will generally use Advocate at Home unless I select a different provider or as directed by my insurance carrier. A list of home care providers is provided to me at Admission/Registration. Upon request, a discharge planner can provide another copy of the list. If I prefer a different provider, my preferences will be honored.

5. EXTERNAL PRESCRIPTIONS: I authorize access to my external prescription history for the purpose of facilitating my care. The information will only be available if my prescriptions were filled through a participating pharmacy. Therefore, it remains my responsibility to provide an accurate medication history

6. LANGUAGE CHOICE: My preferred language for receiving health information is (English). I have been provided information regarding translation and interpreter services. I understand these services are available at no cost and that I may request these services at any time during my admission.

7. LIMITED AUTHORIZATION TO SHARE BILLING AND INSURANCE INFORMATION: By initialing in the space I direct the hospital to release information regarding the status of insurance claims and outstanding balance to the person designated below, who is involved in the payment for my care. I understand this authorization is limited to billing status and insurance status for the treatment event covered by this Health Care Consent. For any future treatment events, I must re-designate this individual to have information shared with him or her. This designation may be revoked at any time by written notice to the Health Information Management/Medical Records Department (with no effect on prior disclosures),

   Initial:_____ **Designee:**_____ **Relationship**_____

8. RELEASE OF MEDICAL INFORMATION FOR PAYMENT: I hereby consent to the release of any and all pertinent information contained in my medical records, including HIV-related information, genetic information, and behavioral health records, to third party payors responsible for payment of patient charges including, but not limited to, insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above.

9. ASSIGNMENT OF BENEFITS: In consideration of services rendered at the hospital, I hereby assign and authorize direct payment to the hospital and the treating physicians, any insurance, health plan or third party payer benefits otherwise payable to me or on my behalf for this hospitalization, emergency room care or outpatient services.

10. MEDICARE PAYMENT AND ASSIGNMENT OF BENEFITS (if applicable): I request that payment of authorized Medicare benefits be made on my behalf for hospital and physician services furnished to me at the hospital and I assign such benefits to the hospital and physicians providing same. I certify that the information given by me in applying for such benefits is correct and that I have completed a Medicare questionnaire. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed for payments of such benefits. I authorize the Social Security Administration to release information about my entitlement to benefits to hospital and physicians providing services to me.

11. PERSONAL BELONGINGS: I assume full responsibility for all items of personal property, including but not limited to, eyeglasses, hearing aids, dentures, jewelry, currency and all other valuables. I understand that valuables may be kept in the hospital safe upon my request and hereby release the hospital of responsibility and liability for those valuables and items of personal property which are not deposited.

12. FINANCIAL ASSISTANCE: In consideration of services to be rendered at the hospital, as the patient or legal representative of the patient, the patient agrees to pay the hospital for all services, facilities and supplies provided to the patient at the established rates, including any deductible, co-payment or charges not covered by third party payors. **I understand that the hospital bill does not include physician services and the patient will receive separate physician bills from physicians for their services.** Some physicians on the medical staff may not participate in the same health plans as the hospital and I understand the patient may have to pay a higher proportion of the physician bill as an "out of network" provider.

The patient accepts responsibility for any costs, including attorneys' fees, incurred in the collection of these charges. I understand that if I do not consent to release of records or later revoke such consent, the patient is fully responsible for payment of all charges for diagnosis and treatment. I certify that the information given by me for purposes of payment for this hospital treatment is, to the best of my knowledge, complete and accurate. I understand that if the patient is having difficulty in meeting his/her payment responsibilities to the hospital, information on financial assistance including reasonable payment plans and financial assistance is available upon request as part of the hospital's financial counseling services. I understand that questions about coverage or benefit levels should be directed to the patient's health care plan and the patient's certificate of coverage. In addition, I have been offered a copy of the financial assistance plain language summary, which describes the financial assistance policy and application.

13. INDEPENDENT PHYSICIAN/PROVIDER SERVICES: I ACKNOWLEDGE AND FULLY UNDERSTAND THAT **ONLY THOSE PHYSICIANS/PROVIDERS WHO ARE CLEARLY IDENTIFIED AS ADVOCATE EMPLOYEES ARE EMPLOYEES OR AGENTS OF ADVOCATE HEALTH CARE. NON-EMPLOYED PHYSICIANS/PROVIDERS ARE INDEPENDENT PROVIDERS WHO ARE PERMITTED TO USE THE HOSPITAL FACILITIES TO RENDER MEDICAL CARE AND TREATMENT.** Non-employed physicians include, but are not limited to, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology and other specialties. These independent physicians/providers exercise their own medical judgment in treating me or otherwise providing professional services to me. I understand that I should ask my physician any questions I may have about his or her employment status. My decision to seek medical care at the hospital is **NOT BASED UPON ANY UNDERSTANDING, REPRESENTATION, ADVERTISEMENT, MEDIA CAMPAIGN, INFERENCE, PRESUMPTION, OR RELIANCE THAT THE PHYSICIANS PROVIDING CARE AND TREATMENT TO ME ARE EMPLOYEES OR AGENTS OF THE HOSPITAL OR ADVOCATE HEALTH CARE.**

By my signature below, I confirm that I acknowledge and understand that the hospital uses independent contractors or practitioners to provide various services as described above. I further acknowledge that I have read this consent form, including the specific language related to independent physician services, and have had the opportunity to ask questions, and that any questions have been satisfactorily answered.

I have read and understand the above terms of treatment and confirm that I am the patient or am authorized to sign on the patient's behalf.

03-09-2021 Date: _____ 10:18 a.m. Time: _____ Patient Name: [redacted]

Patient Signatur[redacted]

(or circle: Parent/Legal Guardian/Personal Representative)

03-09-2021 Date: _____ 10:18 a.m. Time: _____ Witness Signature: _____

Certificate of Interpretation:

I certify that I have interpreted the foregoing to the signor hereof in the _____ *language*

Date: _____ Time: _____ Interpreter: _____

Name/Identification

20414084