Patient Name: [redacted] DOB: [redacted] MRN: [redacted]

CONSENT TO SURGERY
OR SPECIAL PROCEDURE

To: [redacted]

The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you. You should read this form carefully and ask questions of your doctors so that you understand the operation or procedure before you decide whether or not to give your consent. If you have questions, you are encouraged and expected to ask them before you sign this form. "Facility", as referenced below, includes the following entities: Loma Linda University Medical Center, Loma Linda University Children's Hospital, Loma Linda University Behavioral Medicine Center, Loma Linda University Health, Loma Linda University Healthcare and Highland Springs Surgery Center.

The Health Care Professional or Team who will perform the procedure is/are:
ABUDAYYEH, ISLAM, HOFF, JASON MATTHEW

Your providers and surgeons have recommended the following procedure(s):
Left/Right Cardiac Catheterization, IVUS, PCI, FFR, Impella, Intra-aortic balloon pump

And anesthesia, as deemed by the provider, to be finalized on the day of your procedure:

Moderate sedation

Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to any emergency, will be performed on you.
In the event that the above performing provider(s) is unable to perform or complete the procedure, a qualified substitute provider will be selected, together with associates and assistants (including anesthesiologists, pathologists and radiologists), from the medical staff to whom the provider may assign designated responsibilities. Providers and surgeons providing services to me, including the radiologist, pathologist, anesthesiologist and others, are not employees or agents of the facility and are solely responsible for their medical decisions in the evaluation and management of your care. They have been granted the privilege of using the facility for the care and treatment of their patients, but they are not employees or agents of the facility and as such you may be receiving separate bills.

1. The facility maintains personnel and facilities to assist your providers and surgeons in their performance of various surgical operations and other special diagnostic and therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have been informed of such risks as well as the nature and purpose of the operation or procedure and the available alternative methods of treatment, their risks and benefits. However, this form is not a substitute for such explanations which are provided by the above named providers. Except in cases of emergency, operations or procedures are not performed until the patient has had the opportunity to receive such explanations. You have the right to consent to or refuse any proposed operation or procedure.

2. Your providers have recommended the operations or procedures set forth above. Upon your authorization and consent, such operations or procedures, together with any different or further procedures which in the opinion of the supervising provider or surgeon may be indicated due to any emergency or previously unforeseen circumstances, will be performed on you. The operations or procedures will be performed by the surgeon named above (or in the event of an emergency causing his/her absence, a qualified substitute surgeon to be selected by your admitting provider) together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff to whom the surgeon may assign designated responsibilities. The persons in attendance for the purpose of performing specialized medical services such as your surgeon, anesthesia, radiology or pathology are not agents, servants or employees of the facility but are independent contractors, and therefore your agents, servants or employees.

4. The facility pathologist is hereby authorized to use his or her discretion in disposing of any member, organ or other tissue removed from my person during the above named procedure. Scientific studies from tissues obtained in surgical procedures are important to the understanding and development of treatments for the prevention of many disease processes. The facility may receive some tissue specimens from your surgery, and following examination, distribute the material to other scientists or institutions for research and development of products for the diagnosis, treatment, or prevention of disease. Your identity will be kept confidential.

I hereby give permission for the facility, and each of its authorized agents or representatives to distribute tissues or materials obtained during my surgery. I disclaim all proprietary interest in said tissues or materials, including interest in any commercial product developed from this tissue or derivative materials being distributed to scientists or institutions for the research and development of products for the diagnosis, treatment, or prevention of disease,
Except: NONE :

5. For the purpose of advancing medical education, I consent to the admittance of observers to the operating room and also to the taking of non-identifying photographs in the course of this operation and possible publication thereof.

Are there language barriers or other hindrances to communicating with the consentor? NO
If yes, I have obtained the services of a qualified interpreter in obtaining informed consent.

A blood transfusion is anticipated and a type/screen match was done.
NO

PROVIDER CERTIFICATION

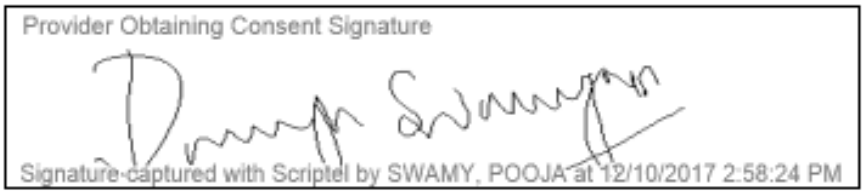
I, the undersigned provider, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including but not limited to:

The common risks and benefits of the procedure;
Specific adverse outcome risks: Air or blood emboli, infection, bleeding, seizure, stroke, dysrhythmias, thrombus formation, hematoma formation, x-ray burs to the skin, perforation of vessel or heart wall, device/stent/coil migration, restenosis/reblockage, death, kidney failure, emergency heart surgery, damage to artery vein
Any adverse reactions that may reasonably be expected to occur;
Any alternative efficacious methods of treatment which may be medically viable;

The potential problems that may occur during recuperation;
The likelihood of achieving treatment goals; and
Any research or economic interest I may have regarding this treatment.

I further certify that the patient was encouraged to ask questions and that all questions were answered.

Provider Obtaining Consent Signature



Signature captured with Scriptel by SWAMY, POOJA at 12/10/2017 2:58:24 PM

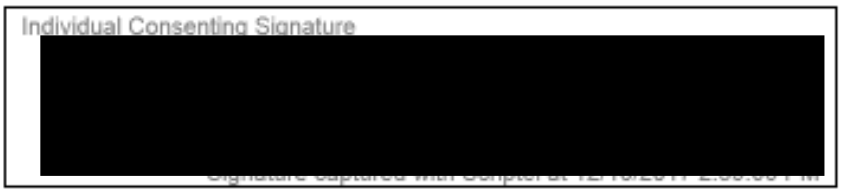
Name of the Provider Obtaining the Consent: SWAMY, POOJA MAHADEV

PATIENT CERTIFICATION

Your signature on this form indicates that:

1. You have read and understand the information provided in this form;
2. Your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with risks, benefits and alternatives, and the other information described above in this form;
3. You have had a chance to ask your doctors questions;
4. You have received all of the information you desire concerning the operation or procedure and the anesthesia; and
5. You authorize and consent to the performance of the operation or procedure and the anesthesia.

Individual Consenting Signature



Signed by Patient

LOMA LINDA UNIVERSITY
LOMA LINDA UNIVERSITY HEALTH CARE
LOMA LINDA UNIVERSITY MEDICAL CENTER
LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL
LOMA LINDA UNIVERSITY BEHAVIORAL MEDICINE CENTER
LOMA LINDA UNIVERSITY HIGHLAND SPRINGS SURGERY CENTER

Patient Name [redacted] DOB: [redacted] MRN: [redacted]

CONSENT TO SURGERY
OR SPECIAL PROCEDURE

To: [redacted]

The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you. You should read this form carefully and ask questions of your doctors so that you understand the operation or procedure before you decide whether or not to give your consent. If you have questions, you are encouraged and expected to ask them before you sign this form. "Facility", as referenced below, includes the following entities: Loma Linda University Medical Center, Loma Linda University Children's Hospital, Loma Linda University Behavioral Medicine Center, Loma Linda University Health, Loma Linda University Healthcare and Highland Springs Surgery Center.

The Health Care Professional or Team who will perform the procedure is/are:
BOLING, WARREN WILSON

Your providers and surgeons have recommended the following procedure(s):
External Ventricular Drain Placement

And anesthesia, as deemed by the provider, to be finalized on the day of your procedure:

Deep sedation

Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to any emergency, will be performed on you.
In the event that the above performing provider(s) is unable to perform or complete the procedure, a qualified substitute provider will be selected, together with associates and assistants (including anesthesiologists, pathologists and radiologists), from the medical staff to whom the provider may assign designated responsibilities. Providers and surgeons providing services to me, including the radiologist, pathologist, anesthesiologist and others, are not employees or agents of the facility and are solely responsible for their medical decisions in the evaluation and management of your care. They have been granted the privilege of using the facility for the care and treatment of their patients, but they are not employees or agents of the facility and as such you may be receiving separate bills.

1. The facility maintains personnel and facilities to assist your providers and surgeons in their performance of various surgical operations and other special diagnostic and therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have been informed of such risks as well as the nature and purpose of the operation or procedure and the available alternative methods of treatment, their risks and benefits. However, this form is not a substitute for such explanations which are provided by the above named providers. Except in cases of emergency, operations or procedures are not performed until the patient has had the opportunity to receive such explanations. You have the right to consent to or refuse any proposed operation or procedure.

2. Your providers have recommended the operations or procedures set forth above. Upon your authorization and consent, such operations or procedures, together with any different or further procedures which in the opinion of the supervising provider or surgeon may be indicated due to any emergency or previously unforeseen circumstances, will be performed on you. The operations or procedures will be performed by the surgeon named above (or in the event of an emergency causing his/her absence, a qualified substitute surgeon to be selected by your admitting provider) together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff to whom the surgeon may assign designated responsibilities. The persons in attendance for the purpose of performing specialized medical services such as your surgeon, anesthesia, radiology or pathology are not agents, servants or employees of the facility but are independent contractors, and therefore your agents, servants or employees.

4. The facility pathologist is hereby authorized to use his or her discretion in disposing of any member, organ or other tissue removed from my person during the above named procedure. Scientific studies from tissues obtained in surgical procedures are important to the understanding and development of treatments for the prevention of many disease processes. The facility may receive some tissue specimens from your surgery, and following examination, distribute the material to other scientists or institutions for research and development of products for the diagnosis, treatment, or prevention of disease. Your identity will be kept confidential.

I hereby give permission for the facility, and each of its authorized agents or representatives to distribute tissues or materials obtained during my surgery. I disclaim all proprietary interest in said tissues or materials, including interest in any commercial product developed from this tissue or derivative materials being distributed to scientists or institutions for the research and development of products for the diagnosis, treatment, or prevention of disease,
Except: NONE :

5. For the purpose of advancing medical education, I consent to the admittance of observers to the operating room and also to the taking of non-identifying photographs in the course of this operation and possible publication thereof.

Are there language barriers or other hindrances to communicating with the consentor? NO
If yes, I have obtained the services of a qualified interpreter in obtaining informed consent.

A blood transfusion is anticipated and a type/screen match was done.
NO

PROVIDER CERTIFICATION

I, the undersigned provider, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including but not limited to:

The common risks and benefits of the procedure;
Specific adverse outcome risks: Infection, external bleeding, internal hemorrhage, brain tissue injury, seizures, complications that can lead to death
Any adverse reactions that may reasonably be expected to occur;
Any alternative efficacious methods of treatment which may be medically viable;
The potential problems that may occur during recuperation;
The likelihood of achieving treatment goals; and

Any research or economic interest I may have regarding this treatment.

I further certify that the patient was encouraged to ask questions and that all questions were answered.

Provider Obtaining Consent Signature

Signature captured with Scriptel by GEZALIAN, MICHAEL M. at 11/22/2017 8:57:00 PM

Name of the Provider Obtaining the Consent: GEZALIAN, MICHAEL MKRTICH

PATIENT CERTIFICATION

Your signature on this form indicates that:

1. You have read and understand the information provided in this form;
2. Your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with risks, benefits and alternatives, and the other information described above in this form;
3. You have had a chance to ask your doctors questions;
4. You have received all of the information you desire concerning the operation or procedure and the anesthesia; and
5. You authorize and consent to the performance of the operation or procedure and the anesthesia.

Individual Consenting Signature

[redacted]

Individual Consenting: Intubated and sedated
Relationship to Patient: Adult Child
Patient Unable to Sign Because: Clyde Fernando

Witness Signature

Signature captured with Scriptel at 11/22/2017 8:57:00 PM

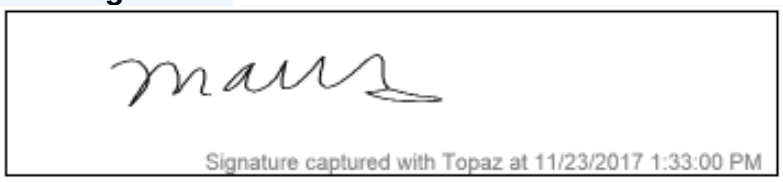
Witness: Taryn Peterson
Title: LVN

Acknowledgement of Receipt of Documents

As part of the admission/registration process, I have provided the patient or the patient's representative the following information (as applicable):

1. Condition of Treatment (COT) ☒
2. Financial Agreement ☒
3. Notice of Privacy Practices (NPP) ☐
4. Patient's Rights Notice ☒
5. Patient Responsibility Notice ☒
6. Important Message From Medicare (IMFM) ☐
7. Charity Care Notice ☒
8. Patient Complaint/Grievance Notice ☒
9. Visitation Rights Notice ☒
10. Family/Personal Physician Notification of Admission Notice ☒
11. Information About My Right to Complete an Advance Directive Notice ☒

Staff Signature:



Staff Signature: Maria Diaz
Date/Time: 11/23/2017 1:32 PM

FINANCIAL AGREEMENT

FINANCIAL AGREEMENT

I agree to promptly pay all hospital bills in accordance with the regular rate and terms of LLUMC, including its charity care and disclount payment policies, if applicable. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separtely for their services. Should any account be referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

Patient Initials: 

ASSIGNMENT OF INSURANCE BENEFITS

I assign and authorize direct payment to LLUMC of all insurance benefits payable for this emergency visit, any outpatient or inpatient services. I agree that the insurance company's payment to LLUMC pursuant to this authorization shall discharge the insurance company's obligations to the extent of such payment. I understand that I am financially responsible for the charges not paid according to this assignment.

HEALTH PLAN OBLIGATION

LLUMC maintains a list of health plans with which it contracts. A list of such plans is available upon request from the financial office. LLUMC has no contract, expressed or implied, with any plan that does not appear on the list. I agree to pay the full charges of all services rendered to me by the hospital if I belong to a plan that does not appear on the contract list mentioned above. All physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others will bill separately for their services. It is my responsibility to determine if physicians providing services to me contract with my health plan, if any.

I agree to accept financial responsibility for services render3ed to me and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits and Health Plan Obilgation provisions above. I am the patient, the patient's legal representative, or am otherwise duly authorized by the patient to sign the above and accept its terms on his/her behalf.

TRANSFER TO CONTRACTED FACILITY

I acknowledge that I may be asked to transfer to my contracted facility for medical treatment once I am stable to do so. I have been informed that I will be financially responsible should I refuse to do so.

Patient Initials: 

Patient/Legal Representative Signature

Relationship to Patient (if signed by Legal Representative): daughter

Witness Signature: Maria Diaz
Date/Time: 11/23/2017 1:29 PM

Interpreted by:
☐ LLUMC Certified Interpreter
☐ Qualified Bilingual Staff
☐ Language Line
☐ Other (relationship)

Interpreter Signature (if present)

LOMA LINDA UNIVERSITY
HEALTH SYSTEM

Patient Name:

AUTHORIZATION FOR PUBLICATION OF CASE STUDY

I, [redacted], give Dr. Purvi Parwani and her team at Loma Linda University Medical Center permission to publish, reproduce, and distribute, the attached Case Study, regarding Coronary Artery Vasospasm. I am aware that the Case Study does NOT mention my name or address, but it does reflect my medical care, gender, age, and medical history.

I have been told that the authors currently plan to submit the case study for publication in a medical journal, for educational purposes.

I will not be paid in any manner for use of the Case Study, as described above. I will not receive any royalties or compensation in connection with any such publication or use.

I am not required to sign this form, and I may refuse to do so. My medical treatment and payment for healthcare will not be affected by whether or not I sign this document.

I may withdraw this authorization for any future sharing at any time by notifying my attending physician in writing, but my withdrawal will not affect information that has already been shared or published. This authorization has no expiration date.

[redacted]

Patient's Name:

[redacted]

Patient's Signature:

1-31-2020

Date:

[redacted]

Patient's Address: