RIVER VALLEY
AMBULATORY SURGERY CENTER

General Consent

- Prior to admission, I received River Valley Ambulatory Surgery Center's patient information packet that includes:
  - Notice of Patient Rights and Responsibilities
  - Patient Privacy Practices
  - Advanced Directive Information
  - Physician Ownership
  - Anti-Discrimination Policy / Complaint Process
  - Surprise Billing
- I consent to medical care/treatments ordered by my physician/anesthesiologist or under the direction of my provider / anesthesiologist, as deemed reasonable and necessary. These additional services including, but not limited to nursing, radiology, pathology, and laboratory. I consent to medical treatment services that are necessary for my total surgical experience.
- I authorize and direct my physician to use his/her discretion in determining the appropriate disposition of any organ, implant prosthetic, or other tissue removed from my person.
- I consent to the presence of other person(s) for the sole purpose of observation education, or technical support. I understand that this individual will not participate in the actual procedure.
- I am aware that my physician may have an ownership interest in this facility, and I acknowledge that I have a right to have my procedure performed in another facility where my physician has privileges.
- I understand that I may be contacted following my surgery/procedure. If I cannot be reached, it is acceptable to leave a message.
- I release the facility from any responsibility for loss and/or damage to money, jewelry, or other valuables I brought to the facility.
- I am aware that x-ray is used in this facility.
- I understand that if I am pregnant, or there is any possibility that I am pregnant, I must inform the facility immediately as my surgery/procedure could cause harm to my child or to myself.
- I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me following my surgery. I acknowledge that I have been advised by facility personnel not to drive until the day after my surgery or as directed by my physician.
- In the unlikely event hospitalization is required before, during, or after my surgery/procedure, my physician will arrange for my transfer to a local hospital.

My signature below constitutes my acknowledgment that I have read or have had read to me the foregoing. I acknowledge my understanding of the above and give consent.

Signature Patient ____ **Date** __________

Signature Guardian ____ **Date** __________

Classified as Confidential