St Joseph's Outpatient Surgery Center – 240 West Thomas Rd – Phoenix, AZ 85013

OUTPATIENT TREATMENT CONSENT

In this document, St. Joseph's Outpatient Surgery Center is referred to as "the Surgery Center" and the person signing this document is referred to as "you.". If you are the Patient, the term "you" in this document refers to you, the patient. You acknowledge and agree to all of the following conditions for outpatient treatment at the Surgery Center.

1. **GENERAL MEDICAL CONSENT:** You consent to the procedures which may be performed on an outpatient basis, which may include but are not limited to x-ray examinations or laboratory procedures or other services rendered under the general and special instructions of your attending physician or surgeon.

2. **ACKNOWLEDGEMENT OF PARTICIPATION OF PHYSICIAN RESIDENTS AND HEALTH CARE STUDENTS:** The Surgery Center may participate in various teaching programs through which physician residents, medical students, student nurses. And/or students in other health care fields receive training as part of their education thru St. Joe's Hospital and Medical Center. From time to time, these persons may participate in your care as part of their education program, unless you indicate that you do not agree to such participation. Such persons are under the supervision of licensed professionals.

3. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN:** All physician furnishing services to you,
Including but not limited to, radiologists, pathologists, emergency physicians and anesthesiologists are
Independent contractors and are not employees, representatives of agents of the Surgery Center. You are under the care and supervision of your attending physician and it is the responsibility of the Surgery Center and its nursing staff to carry out the instructions of that physician and any other consulting physicians. It is the responsibility of your physician(s) to obtain your informed consent, when required, to medical or surgical outpatient treatment, special diagnostic or therapeutic procedures, or outpatient services rendered to you under the general and/or special instructions of your physician(s).

4. **RELEASE OF INFORMATION**: Except in those instances where the Surgery Center Is permitted or required by state or federal law to release information about you, the Surgery Center will obtain your consent and your written authorization to release information about services rendered to you as an outpatient. The law provides that your consent must be obtained so that the Surgery Center may use or disclose your medical information to provide medical treatment to you, and to the extent necessary for health care operations and to determine liability for payment or to obtain reimbursement By signing below you acknowledge your consent, or your legal representative's consent on your behalf. Disclosure may be made to any person or corporation that may be liable for any of the Surgery Center's charges. Health care operations may be performed by the Surgery Center or its authorized agents, who will also have a binding obligation to maintain the confidentiality of your patient Information. Special permission may be required to release this information, or other limitations on release may apply, if you are treated for alcohol, drug abuse, or Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), or if you receive certain mental-health related services.

5. **ADMISSION TO HOSPITAL:** In the event of an unforeseen circumstance that cannot be accommodated on an outpatient basis, it may be necessary to admit you to the Hospital for treatment. May we request a copy of your transfer summary?
YES _____ NO_____

Acknowledgement And Consent by Patient or Patient's Legal Representative or Authorized Agent.

You certify that you have read, understand, and agree to the foregoing, have received a copy of it, and are either the patient, the patient's legal representative, or the person authorized by the patient to act as the patient's agent to execute this document and to accept its terms.

Name: ___ _____Signature: _____Date:_____
(Please print name)

If signed by anyone other than the patient, please indicate relationship: _____