SJVSC South Jersey Vascular Surgery Center

Center/Treatment Consent

Consent for Treatment:

I, the above named and undersigned patient, give my consent for care at and by the medical, nursing, allied professional staff of the **South Jersey Vascular Surgery Center, ("Center")**, which may include routine diagnostic procedures and such medical treatment as my doctor or his / her designees may find are needed. I acknowledge that no promises or guarantees have been made to me about the results of any examinations, treatments or procedures I may receive while at the Center.

Release of Medical Records:

I authorize **South Jersey Vascular Surgery Center** to release all or any part of my medical record to **A.** hospitals or medical service companies, insurance companies, workmans' compensation carriers, welfare funds, or other organizations or agencies that may be concerned with the payment of costs related to my treatment and **B.** any other organization of agency to which the Center is permitted to release such information under applicable laws. In the event I am transferred or admitted to a hospital, post-operatively or require ER care within 72 hours postoperatively *for this visit or any future visits at this center,* I authorize the Center to obtain a copy of the discharge and or medical record summary.

Financial Arrangements:

I authorize and direct my insurer/ Medicare/ or payor to pay directly to the above Center any or all benefits, up the amount of my bill, accruing to me about my treatment. I agree that, in consideration of the services that were provided to me, I individually obligate myself to pay the amount promptly in accordance with the regular rates and terms of the Center. Regulations to Medicare assignment of benefits apply. I understand, therefore, that to the extent permitted under applicable laws and contractual arrangements, I am financially responsible to the Center for any amounts not covered by my insurance. Furthermore, I understand that my insurer or payor may require myself to pay the account of the Center with respect to the services that I choose to receive notwithstanding that my health insurer or payor has refused to give pre-authorization of all or any portion of my services.

Pre- Certification:

Your insurance company will be called to pre-certify your procedure. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for physician and hospital services. I understand that my insurance plan will hold me responsible for a deducible and / or co-insurance.

Center Fees: If you have any questions regarding the above information, please ask the Administrator

When your procedure is performed at the Center, there will be a "facility" fee. There is a charge for the use of the surgical OR/suite for your procedure. Fees will vary according to the type of procedures that is / are being performed. Patient responsibility is dependent upon individual insurance plans.

Collection Expenses: (Medicare/Medicaid excluded)

Should my account with the Center be referred to an attorney or outside agency for collection, I will pay all reasonable collection expenses (included attorney's fees) associated with the collection effort. I acknowledge that all delinquent accounts will bear interest at the legal rate.

Attending Provider Fees:

These are the fees that are billed by your Physician for his/her services in performing your procedure. These fees are within the range considered usual and customary for this area. Patient responsibility will vary according to each insurance plan. For questions pertaining to you Physicians' bill, please contact your Physician's office.

_____ Attending provider is **in-network**

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Patient Rights & Privacy Practices:	
I have been offered a copy of:	
A. Patient Rights & Responsibilities	❑ **Yes** ❑ **No**
A. Advance Directive Policy/Info	❑ **Yes** ❑ **No**
B. Disclosure of Ownership	❑ **Yes** ❑ **No**
C. HIPPA Privacy	❑ **Yes** ❑ **No**

Living Will:	
I have an Advance Directive	❑ **Yes** ❑ **No**
I have brought my Advance Directive with me	❑ **Yes** ❑ **No**
Information on Advance Directives was offered to me	❑ **Yes** ❑ **No**

***It is the policy of the Center, regardless of the contents of an Advance Directive or instructions from a healthcare surrogate or Power of Attorney that if an adverse event occurs during treatment,* "**the Center personnel will initiate resuscitative or other stabilizing measures and transfer the patient to an acute care hospital for further evaluation**"**

Clothing and Valuables:

I fully understand that the Center is not responsible for any personal property (clothing, eyeglasses, dentures etc.) brought in or retained in the lockers at any time. I fully understand that any valuables (money, jewelry, keys, etc.) should be given to a family member or other responsible party for safekeeping.

Driving Risks:

I have been informed by **South Jersey Vascular Surgery Center** that I should not drive for at least 24 hours after completion of my procedure if I have received sedation or pain medication.
A responsible adult, upon discharge from the Center will accompany all patients who have intravenous sedation anesthesia.

All patients who have had local anesthesia without sedation, and who meet the discharge criteria may be discharged unescorted.

I acknowledge that I have read this form (or that it has been read to me). I understand the contents and significance as they have been explained to me. I have been given an opportunity to ask questions, which have been answered to my satisfaction.

Date: _____

Signature of Patient / guardian	Print Name
Witness	Print Name