***Surgicare*** OF MANHATTAN
800 Second Avenue, New York, NY 10017

**CONSENT to Surgical Procedure, Invasive Test, Procedure, Treatment and/or Anesthesia**

I hereby authorize Dr. Stuart D. Katchis and his/her associates or assistants to perform upon the named patient or me the following surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s): _____

_____

_____

Including such photographing, videotaping, televising or other observation of the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s) as may be purposeful for the advancement of medical knowledge and /or education, with the understanding that my/the patient's identity will remain anonymous.

The purpose of the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatments(s) has/have been explained to me and I have also been informed of the expected benefits and possible complications, attendant discomforts and risks that may arise, as well as possible alternatives to proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I understand that during the course of the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s) that unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s) which the above-named physician or practitioner or his /her associates or assistants may consider necessary.

I consent to the release of my social security number to the manufacturer of any device that is surgically implanted in me during my admission. I understand release of my social security number is for the purpose of helping the manufacturer locate me if there is a need to contact me with regard to the implanted medical device.

I understand that the use and type of anesthesia, sedatives or analgesics which may be considered necessary will be explained to me by the Anesthesiologist before surgery or by the physician or practitioner administering the medication prior to any surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s). The risks, benefits and alternatives to their use will also be explained to me.

I understand any organs or tissues surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with customary practices.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s).

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above, which do not pertain to me.

**Patient/Healthcare Agent/Guardian/Next-of-kin:** _____
Signature

_____
Print Name Date

**Relationship:** _____
(If signed by other than patient)

**Witness:** _____ **Interpreter:** _____
Signature

**Physician/Practitioner Certification**

I hereby certify that the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks), the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s) and blood transfusion(s) have been explained to the patient. Any and all questions have been answered. I believe that the patient/healthcare agent/guardian/next-of-kin fully understands what has been explained.

**Physician/Practitioner** _____ Stuart D. Katchis, M.D _____
Signature/Title Print Name Date

**DISCLOSURES**

A. In accordance with Chapter IV. Title 42, Section 420.206 (Department of Health and Human Services, Centers for Medicare Medicaid), I have been informed in writing prior to the date of my treatment, that Dr. _STUART_KATCHIS__ has a financial interest in SurgiCare of Manhattan. I have also been informed that I may seek treatment at any other surgery center, hospital or provider of my selection.

B. In accordance with Medicare Conditions for Coverage #416.50 (a), I or my representative have received notice of the patient's rights in advance of the date of the procedure in a language and manner that is understandable.

C. In accordance with Medicare Conditions for Coverage, #416.50 (a), I or my representative have received information concerning the SurgiCare of Manhattan's policies on advance directives, including a description of the applicable State health and safety laws and if requested, official State advance directive forms.

_____ _____
Patient's Signature Date

_____
Patient's Name (Print)

_____ _____
Patient/Healthcare Agent/Guardian Relationship
(if other than the patient)