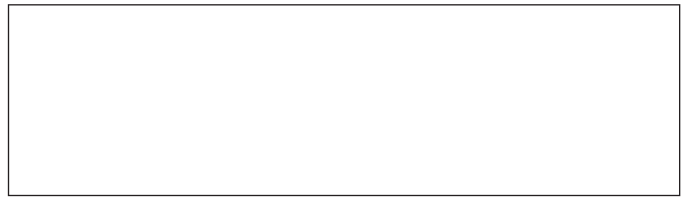
Brighton Surgery Center, LLC



Procedure Authorization Form and Attestation of Informed Consent

I, (print name) ____________________________ For ______________(myself/minor child), hereby authorize the following treatment or procedures (collectively the "Procedure"): ____________________

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to be performed at Brighton Surgery Center, LLC ("BSC") by or under the direction of

Dr. ____.

1. My Provider has explained to me* in a manner which I understand, the nature of my ailment and my need for treatment. My Provider has answered all my questions to my satisfaction.

2. My Provider has explained to me the nature, likelihood of success, typical risks (including problems related to recuperation) and potential benefits of the Procedure. I understand that the Procedure does not guarantee improvement of my ailment or condition. These operations and procedures, as well as the administration of anesthesia, may all involve risks, unsuccessful results, complications, infection, bleeding, injury or even death, both from known and unforeseen causes. I also understand that there are other less common risks of the procedure and the related care that have not been explained but will be explained at my request. My Provider has also explained to me the alternatives to the Procedure, including no treatment at all.

3. I consent to the administration of anesthesia as determined by My Provider, and/or BSC anesthesia staff which may include both Licensed Anesthesiologists and /or Licensed Certified Nurse Anesthetists. For moderate sedation cases my Provider may directly supervise a Register Nurse to provide sedation. I have been informed of the risks, benefits and alternatives to the use of moderate sedation agents.

4. I authorize BSC to dispose of any tissues or implants removed as a result of the Procedure, or to preserve such tissues or implants at its discretion for scientific or teaching purposes.

5. I further authorize My Provider to carry out whatever additional or different procedure(s) or method(s) of treatment he/ she may deem necessary or advisable in the event that unforeseen conditions arise during the course of the Procedure.

6. I consent to the photographing and/or videotaping of the Procedure for medical, scientific, or educational purposes provided that my identity is not revealed. The prints or negatives, and/or the videotapes shall be the property of BSC or My Provider. I waive all rights of ownership or payment of any kind in connection with the prints, negatives, or videotapes and understand that they will not be made available to me under any circumstances.

7. I understand there may be students, vendors, other physicians and/or sales representatives, present during my care, at the surgery center, including in the Operating Room. I hereby give my Provider, together with such assistants/associates as may be selected by him/her, my informed consent for this Procedure.

______________________________________ Guardian Relationship:____________________

Patient or Parent/Guardian Signature

______________________________________ Witness:____________________________

Doctor Signature

Date:____________________ Time__________

**As used in this Procedure Authorization Form, the terms "me" and "my" refer to a patient for whom the patient/guardian is authorizing treatment.*

Consent updated: ______________________________ Date: ____________ Time: ________

Patient or Parent/Guardian Signature

If consent was greater than 90 days old. ______________________________ Date: ____________ Time: ________

Doctor Signature

The following has been discussed with the patient and/or surrogate, and/or proxy: