CONSENT FOR ANESTHESIA

I _____, for _____

1. As____Parent, ___Guardian, ___Representative, acting on his/her behalf, am asking to receive anesthesia during his/her pending procedure/operation/treatment. I want to have anesthesia in order to lessen the pain I would otherwise experience.

2. The anesthesia I receive may include (but not limited to) general anesthesia, nerve block, spinal/epidural, intravenous sedation or intravenous regional. The choice and type will be selected according to the type of procedure/operation/treatment, patient satisfaction, safety and surgeon/anesthesiologist choice.

3. It has been explained to me that all forms of anesthesia involve some risk and no guarantee or promises can be made concerning the results of my treatment. Although rare, unexpected severe complications with anesthesia can occur and include the possibility of infection, bleeding, drug reaction, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death, convulsions, injury to blood vessels, awareness, aspiration, pneumonia or blindness. I understand that these risks apply to all forms of anesthesia.

4. Some, but not all, of the common foreseeable risks and consequences of anesthesia are sore throat and hoarseness, nausea and vomiting, muscle soreness and drying of the eyes. Further, I am aware that instrumentation in the mouth to maintain an open airway during anesthesia might unavoidably result in dental damage including fracture or loss of teeth, bridge-work, dentures, crowns and fillings, laceration of the gums or lips.

5. I understand that medications that I may be taking may cause complications with anesthesia and surgery and it is in my best interest to inform my doctor about the nature of any medication to include but not limited to aspirin, cold remedies, narcotics, PCP, marijuana, cocaine or other illicit substances.

6. I understand that during my procedure/operation/treatment invasive monitoring may be necessary. I understand the risk/benefit associated with this type of monitoring which has been explained to me.

7. I understand that sometimes an anesthesia technique which involves the use of local anesthetics or regional block, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

8. I understand that I must not eat or drink anything, not even water, after 12:00 midnight the day prior to surgery unless directly permitted by the anesthesia staff.

9. Should the need arise during my operation or the immediate post-op period, I also consent to the administration of blood and/or blood products. I understand that despite careful testing and screening of blood/blood products by collecting agencies, I may still be subject to ill effects of a transfusion. Some, but not all, of the potential risks that can occur are fever, allergic reaction, hemolytic reactions, transmission of diseases such as hepatitis, AIDS and cytomegalovirus (CMV), and fluid overload.

10. I hereby consent to the administration of anesthesia under the supervision of Ambulatory Anesthesia of North Georgia, LLC and all its associates, all of whom are credentialed to provide anesthesia services at the healthcare facility, but who are all independent practioners and not employees or agents of this healthcare facility.

11. By signing this request form, I am indicating that I understand the content of this document, agree to its provisions and consent to the administration of anesthesia during my procedure/operation/treatment. I know that if I have concerns or would like more detailed information, I can ask more questions and get information from my attending physician. I am also acknowledging that I know that the practice of anesthesiology/medicine/surgery is not an exact science and that no one has given me any promises or guarantees about the administration of anesthesia or its results. I understand the risks/complications mentioned are not meant to be a totally inclusive list.

Signature_____Date_____

Signature_____Time_____

WHITE – CHART YELLOW – PATIENT

Ambulatory Anesthesia of North Georgia, LLC
CONSENT FOR ANESTHESIA &
ASSIGNMENT OF BENEFITS STATEMENT

PATIENT IDENTIFICATION

_____
Witness

Ambulatory Anesthesia of North Georgia, LLC
CONSENT FOR ANESTHESIA &
ASSIGNMENT OF BENEFITS STATEMENT

ASSIGNMENT OF BENEFITS STATEMENT

On my behalf, I, _____, authorize Ambulatory Anesthesia of North Georgia,
(Print Patient Name)
LLC, to file a claim for payment of their professional services to my insurance company, or companies, in accordance with all applicable state and federal laws.

I specifically direct my insurer(s) to pay Ambulatory Anesthesia of North Georgia, LLC, not me or my beneficiaries, upon receipt of that claim for services.

Should I be paid personally by my insurer(s), I will guarantee payment to Ambulatory Anesthesia of North Georgia, LLC for the full amount allowed or allowable under federal or state law or under any existing contract arrangement between my insurer(s) and Ambulatory Anesthesia of North Georgia, LLC.

I agree that I am required to pay Ambulatory Anesthesia of North Georgia, LLC for its services provided to me in the event that my insurance does not cover all or any portion of the fees for those services.

I agree that should the account be placed with the collection agency, that I will be liable both for the balance of my account and to reimburse Ambulatory Anesthesia of North Georgia, LLC for all fees, court costs, and attorney's fees that is required to pay in order to collect the balance of my account.

Notice of Privacy Practices
Ambulatory Anesthesia of North Georgia, LLC

As a patient of Ambulatory Anesthesia of North Georgia, LLC, we want you to know that the confidentiality and privacy of your medical information provided to us is protected under federal and state laws. We are providing you with a summary of our official Notice of Privacy Practices that became effective April 14, 2003. Our Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information.

In the normal course of our business, we may share your protected health information (PHI) with others to the extent necessary to facilitate your treatment, streamline payment and conduct quality improvement efforts. Examples of others who may need access to your PHI include your insurer(s), our billing software vendor, our attorneys and outside consultants.

Except disclosures and uses permitted or required under federal and state law or for the purposes of treatment, payment or healthcare operations, all other disclosures of your PHI required your written authorization. You have the right to revoke any written authorization you have provided to us to the extent that we have not taken action in reliance upon your written authorization.

To the extent provided under applicable federal and state law you have the right to (1) request restrictions on certain uses and disclosures of your PHI, (2) inspect and copy your PHI, (3) request amendments to your PHI, (4) receive an accounting of certain disclosures of PHI, (5) request confidential communication of PHI, and (6)
Obtain a copy of our Notice of Privacy Practices upon request. You may request a copy of our Notice of Privacy Practices by calling our office at (770) 532-7179 or directing your request to our Privacy Office at Ambulatory Anesthesia of North Georgia, LLC at 1488 Jesse Jewell Parkway, Gainesville, Georgia 30501.

Our Notice of Privacy Practices is subject to change in the future and any change will be effective for medial information we already have about you as well as any information we may obtain in the future. If you have any questions, you may contact our Privacy Officer. Any complaints should also be directed to our Privacy Officer at (770) 532-7179 or at the Office of Civil Rights at 1-877-696-6775.

_____ _____
Signature of Patient Date