

**LEGACY SURGERY CENTER**  
**DISCLOSURE AND CONSENT TO MEDICAL AND SURGICAL PROCEDURES**

**To Our Patient:**

You have the right as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be performed so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Dr. \_\_\_\_\_ as my physician, and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition, which has been explained to me as: \_\_\_\_\_

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I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (w) voluntarily consent to and authorize these procedures:

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I (we) understand that my physician may discover other or different conditions, which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgment.

I (we)  (Do)  (Do not) consent to the use of blood and/or blood products or other fluids as deemed necessary. I (we) understand the risks and hazards associated with the use of blood and blood products are: fever, transfusion reaction, which may include kidney failure or anemia, heart failure, hepatitis, AIDS (Acquired Immune Deficiency Syndrome) and other infections.

I (we) understand that each patient is admitted under the care of the patient's attending physician. I (we) understand that although all physicians practicing at Legacy Surgery Center are members of Legacy Surgery Center's medical staff, they are not agents or employees of the facility and are not authorized to make representations on behalf of the facility. Specifically, I (we) understand radiologists, pathologists, anesthesiologists, and all other physicians, are independent contractors and are not agents or employees of Legacy Surgery Center. I (we) further understand and agree that Legacy Surgery Center is not liable or responsible for the care and treatment rendered to the patient by the physician members of the Surgery Center's medical staff.

I (we) understand that no warranty or guarantee has been made to me as to the results or cure.

Just as there are risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reaction, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:

Risks and hazards discussed by physician: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthesia for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed, possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards, which may result from the use of general anesthetics, range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we)  (Do)  (Do not) authorize my doctor and/or such assistants as he/she may select to photograph or video tape me. I (we) understand that the photographs/video will be used only for medical and educational purposes and will not be released for publication in any other context with my expressed written permission.

I (we)  (Do)  (Do not) consent to the disposal of any tissue or parts that may be removed in accordance with customary practice.

For purpose of advancing medical education, I (we)  (Do)  (Do not) consent to the admittance of students and persons required for technical support to the room in which the procedure is performed.

I (we) understand that I am scheduled to go home after my surgery and I must have a responsible adult to drive me home and stay with me as advised by my physician.

I (we) understand the surgery is intended to be performed on an outpatient basis. I consent to my transfer to a hospital or other facility should my physician(s) deem it advisable or necessary.

I (we) understand the Surgery Center is not responsible or liable for the loss of or damage to any article of value that I have brought to this facility.

I (we) understand that Texas law provides and I (we) agree, that if any healthcare worker is exposed to my blood or other bodily fluid, to allow the Legacy Surgery Center to perform tests on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, hepatitis, human immunodeficiency virus (which is the causative agent with AIDS). I (we) understand that the results of such tests do not become part of my medical record.

The nature, purpose, and possible complications of the procedure and medical services described above; risks and benefits reasonably expected; and the alternative methods of treatment have been explained to me (us) by the physician; and I (we) understand the explanation I (we) have received.

I (we) certify this form has been fully explained to me (us), that I (we) have read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

I have explained the procedures, risks, hazards, and benefits to the patients and have obtained informed consent.

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Signature: \_\_\_\_\_  
Patient Witness Time

If the patient is a minor or unable to sign, complete the following:

- Patient is a minor
- Patient is unable to sign because \_\_\_\_\_

\_\_\_\_\_  
Patient Parent Legally Designated Representative

\_\_\_\_\_  
Relationship to Patient if Patient Does Not Sign