Consent for Examination and Treatment

I have come to the Outpatient Hospital (Center) to get medical treatment. I voluntarily consent to the examination and treatment deemed necessary by my physician, including but not limited to medical, surgical, laboratory, and x-ray services. I understand that the physicians who provide services to me are not employed by the (Center), but are independent contractors who are permitted to use the Center's facilities to care for and treat their patients. I agree that the Center and my physician may obtain specimens and tissue as appropriate for my diagnosis and treatment and their respective health operations, and I hereby authorize the Center to dispose of any specimens or tissues taken from my body. I consent to video or the use of other electronic monitoring or recording method necessary for my treatment or safety. I understand that the Center is not able to prepare certain compounded medications. In the event that I need compounded medications that the Center is not able to prepare, I consent to receive compounded medications prepared by a pharmacy contracted to provide those services.

Patient Rights, Grievance Process, and Advanced Directives

I have received or have been informed of my rights and responsibilities as a patient. I understand that the Center has a process to address and resolve any concerns, complaints, or grievances. I may call the Administrator to assist me in addressing and resolving these issues. I understand under Virginia law, I have the right to determine in advance or to choose in advance someone to determine for me what kind of medical or surgical treatment I would want if I am incapable of communicating to my doctor what kind of treatment I want. I acknowledge that the Center has available to me "Your Right to Decide" regarding these "advance directives." If I already have an advance directive, I will provide a copy to be placed in my medical record, and I understand that the Center cannot follow the directive of my advance directive until I do provide it or draft a new one. If I do not already have an advance directive, I may contact one of the Pre-Operative Nurses if I wish to discuss one.

Interpreter Services and Auxiliary Aids

I understand that the Center provides professional medical interpreters to patients and their companions who are Limited-English-proficient or who are deaf. Interpreters are available 24/7 at no cost to patients or families. The Center provides appropriate auxiliary aids free of charge, including, but not limited to TTYs, written materials, assistive listening devices, and closed caption decoders.

Students and Medical Residents

I understand that the Center does participate with healthcare education programs and I agree that students may participate in my care. I understand the medical residents who have completed medical school may be involved in my care.

Deemed Consent

I understand that under Virginia law, if, while examining or treating me, any person employed by or under the direction and control of the Center or any other healthcare provider is directly exposed to my body fluid in a manner which may transmit HIV, Hepatitis B or Hepatitis C, I will be deemed to have consented to testing for HIV, Hepatitis B or Hepatitis C infection and to the release of the test results to the exposed person.

Release of Information

I authorize the Center to disclose all or any part of my medical record or other information to any person or entity in accordance with and for purposes permitted by federal and state law, including but not limited to infectious disease reporting and peer review. I also authorize the release of information to the treating physician and to any physician(s) or health care facility to which I may be referred or transferred. I authorize the release of information to prospective or actual agencies that may need this information to determine if they can provide me services.

Personal Valuables/Possessions

I understand that the Center does not have a safe for the safekeeping of a patient's money or valuables. It is recommended that I keep money and valuables at home. I accept responsibility for any possessions kept by me including, but not limited to, dentures, glasses, contact lenses, hearing aids, and electronic devices.

Certification

I certify that I have read this entire form, that I was given a chance to ask any questions I had about this form, that all of my questions about this form have been answered, and that I understand the content and purpose of this form. I certify that I am the patient, or that I am a person authorized by the patient and/or in accordance with Virginia law to sign this form and accept its terms.

Patient or Legal Surrogate	Date/Time	Relationship to Patient

MWHC Fredericksburg Ambulatory Surgery Center

* CO0610*

/Patient Identification

FASC General Consent for Treatment