Methodist MANSFIELD
AMBULATORY SURGERY CENTER

CONSENT TO TREAT

General Consent: I understand that my health condition requires outpatient admission. I consent to and authorize testing, treatment and Ambulatory Surgery Center (ASC) care by ASC nurses, employees, and others as ordered by my doctor and his/her consultants, associates, and assistants, or as directed pursuant to standing medical orders or protocols. I understand that it may be necessary for representatives of outside health care companies to assist in my care. I also understand that persons in professional training programs may be among the individuals who provide care to me. I understand that in connection with my treatment, photos or video may be taken. Any tissue or body parts removed from my body may be retained or disposed of by the ASC at its sole discretion.

Communicable disease testing: I acknowledge that Texas law provides if any health care worker is exposed to my blood or other bodily fluid the ASC may perform tests, without my consent, on my blood or other bodily fluid to determine the presence of hepatitis B and C and HIV. I understand that such testing is necessary to protect those who will be caring for me while I am a patient at the ASC. I understand that the results of tests taken under these circumstances are confidential and do not become a part of my ASC patient record.

Release of Information: In general, medical information concerning the patient's procedure is treated as confidential by the ASC, its personnel and members of its medical staff. I authorize the ASC to release any information necessary for the purpose of determining coverage to my insurer or other entity responsible for claims payment without my further written consent.

THCIC – PATIENT NOTIFICATION OF DATA COLLECTION:
This document shall provide notice to patients that the Texas Department of State Health Services, Texas Healthcare Information Collection program (THCIC) receives patient claim data regarding services performed by the named Provider. The patients claim data is used to help improve the health of Texas, through various methods of research and analysis. Patient confidentiality is held to the highest standard and your information is not subject to public release. THCIC follows strict internal and external guidelines as outlined in Chapter 108 of the Texas Health and Safety Code and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I AM EITHER A PATIENT, PARENT, LEGAL GUARDIAN OR AM DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

I UNDERSTAND AND AGREE THAT, AT THE TIME THE PATIENT HAS MET THE ASC'S MEDICAL CRITERIA TO LEAVE THE FACILITY, I WILL HAVE A RESPONSIBLE ADULT PRESENT TO TAKE ME / PATIENT HOME. I RELEASE THE ASC FROM ANY RESPONSIBILITY FOR EVENTS IN VIOLATION OF THIS AGREEMENT.

If the person signing this form is not the patient, please give full name, phone number and address:

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I have read and understand this information.

_____	_____	_____	_____
Signature of patient or legally authorized Representative*	Relationship to Patient	Reason Patient Unable to Sign	Date/Time of Signature

_____	_____	_____
Witness	Title	Date of Signature

Patient Label