Robert Wood Johnson
Endosurgical Center

800 Ryders Lane East Brunswick, NJ 08816
Tel: (732) 432-6880 Fax: (732) 432-6885

Patient Name:

Date of Birth:

Procedure Date:

Physician:

Procedure:

Details:

Level:

Pain Management Informed Consent

1. I hereby authorize _____ ("physician") and associates or assistants of his/her choice to perform the following operation and any other procedure as he/she may deem necessary or advisable, on me.

2. This is to verify that I was instructed not to eat, drink, or take and medication (unless specified by my physician) after midnight last night and that I have followed those instructions.

3. I recognize that, during the course of the operation/procedure(s) unforeseen conditions may require additional or different operation/procedure(s) other than those listed. Should this occur, I ask that the above names physician or his assistants perform such operation/procedure(s) as are, in his professional judgment, necessary and desirable. This authority shall extend to treating conditions that are not known to my physician(s) at the time of the operation/procedure(s) is (are) begun.

4. The basic procedures of my surgery and the advantages and the disadvantages, risks and possible complications of alternative treatments have been explained to me by the doctor. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to satisfaction. As with ALL types of surgery there is the possibility of other complications due to anesthesia, drugs, reactions or other factors which may involve other parts of my body, including a possibility of brain damage or even death. Since it is impossible to state every complication that may occur as a result of surgery, the list of complications in this form is incomplete.

5. I hereby authorize and direct the above named surgeon to arrange for such additional services for me, as he/she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performances of services involving pathology and radiology and I hereby consent thereto.

6. I further consent to disposal by surgery center authorities, in accordance with its accustomed practice, of any tissue or parts, which may be removed.

7. If any unforeseen condition arises during the procedure calling for additional procedures or medications (including anesthesia and blood transfusions), admission to the hospital, or surgery. I further request and authorize him/her to do whatever he/she deems advisable in my interest. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure. If my physician or member of the center's staff has exposure to one of my body fluids during this procedure, I consent to the testing of my blood for the human immunodeficiency virus (HIV) and hepatitis.

8. I/We hereby authorize all doctors, pharmacies, RWJ Endosurgical Center or other institutions rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered, (including copies of their records).

9. I acknowledge that I have been advised by RWJ Endosurgical Center personnel that it is my responsibility to arrange for a responsible adult to drive me home and that I should not drive until the effects of any medication that I receive have worn off. This means I understand that I should not drive until the day after my operation.

10. I am aware that the manufacturer's representatives and other observers may be admitted to the operating or treatment room if approved by the physician.

11. I hereby consent to the use of video-taping or photography of my surgery at my surgeon's discretion and release RWJ Endosurgical Center from all liability from claims of any kind for the taking and use of these photographs or tapes.

12. I consent to the administration of anesthesia and the use of such anesthetics as may be deemed advisable by the physician or anesthesiologist responsible for this service to me. Benefits and risks of anesthesia have been explained. Risks include, but are not limited to changes in heart rate, breathing and/or blood pressure or inflammation at the site of injection.

I AM STATING THAT I HAVE READ THIS CONSENT (OR IT HAS BEEN READ TO ME), AND I FULLY UNDERSTAND IT AND THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM THE SURGERY. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL THE ITEMS LISTED IN THESE PARAGRAPHS.

Insurance Authorization and Assignment

I request that payment of authorized Medicare/other insurance company benefits be made either to me on my behalf or to the RWJ Endosurgical Center for any services furnished (to) me by that third party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim/other Insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.)

Irrevocable Assignment of Benefits/Guarantee to Cooperate

In consideration of services rendered or to be rendered to the patient named below, I hereby authorize and assign payment and all first party no-fault automobile insurance benefits directly to the above named provider to which I am otherwise entitled for services rendered by the provider. This provider in turn agrees to comply with the requirements of the no-fault insurance carrier's precertification plan / decision point review plan and the provider agrees not to seek to obtain payment from the insured or persons receiving treatment or undergoing medical testing whenever charges have been reduced in accordance with the no-fault carrier's precertification plan.

I authorize, assign and direct payment of insurance benefits to the above referenced provider's office for monies due on bills which relate to services rendered. I assign to the above provider's office the right to prosecute the claim(s) against the insurance carrier who affords benefits and I agree to fully cooperate with this provider's office's efforts to prosecute a claim against the insurance carrier if there is not timely payment on the claim.

In the event the provider's charges are outstanding and I fail to file an application for benefits under the State No-Fault laws, I hereby authorize the provider to file such a claim on my behalf so that the provider may realize payment of its charges. I also authorize the above referenced provider to release any medical information necessary for the use of attorneys, doctors, insurance companies or collection services.

As part of my assignment of benefits, I specifically request that my insurance carrier forward to the provider copies of any and all reports from Independent Examiners, Peer Review Doctors and auditing companies.

Additionally, should I recover any money by virtue of claim or legal cause of action, I hereby assign my right to payment directly to the health care provider named above and I direct my attorney or other legal representative to honor this irrevocable assignment as a lien on my file for any funds that may be due me. My attorney or legal representative is hereby authorized and directed to make such payment from the recovery in such claim or action up to the amount due to the above provider so as to be consistent with this assignment. This assignment will also serve as a letter of protection for the provider. This letter of protection grants the provider the ability to recover outstanding balances, which are not due to fee scheduling reductions, from any and all settlements I may recover.

I understand that the above assignment may not be revoked or amended without the express written consent of the above mentioned provider. Additionally, by signing the agreement I fully understand the terms contained therein. My signature also represents that I fully understand this agreement if I needed assistance interpreting it. I have not been coerced in any way to give this assignment. If any portion of this form is found to be invalid, the remainder shall remain in effect. A photocopy of this shall be deemed as valid as the original.

Laboratory Testing

During the course of your procedure it may be necessary for your physician to obtain and send tissue samples, blood samples, or request other laboratory testing. The State of New Jersey now requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative. Therefore, it is necessary for the RWJ Endosurgical Center to receive authorization from the patient in order for us to allow the laboratory to bill your insurance company for you.

Patients' Rights and Privacy Practices

I have been given a copy and an explanation of the NJ Patients' Bill of Rights with grievance process.

I have been given a copy and an explanation of the HIPAA Notice of Privacy Practices.

I have been made aware of physician ownership.

I have been made aware of the NJ Out of Network Consumer Protection Transparency Cost Containment Accountability Act.

Advanced Directive

Advance directives or "living wills" are recognized in the state of New Jersey as legal documents which offer evidence of an individual's medical treatment preferences. The United States Supreme Court affirmed, in its Cruzan decision, that an individual's persona; wishes are then subjected to constitution protection. I understand that I am not required to have an Advanced Directive in order to receive medical treatment in this health care facility. I further understand that it is the policy of this facility to resuscitate patients that require resuscitation in order to maintain their vital functions. In case of an emergency I understand that I may be transferred to a local hospital for treatment.

Valuables Release

I agree that the RWJ Endosurgical Center is not responsible for any valuables that I have elected to bring.

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Signature of Patient/Legal Guardian Date Signature of Witness Date

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Signature of Physician Date Signature of Anesthesiologist Date