RETINAL AMBULATORY SURGERY CENTER OF NEW YORK, INC.
138-140 EAST 80 STREET
NEW YORK, NY 10075

PAITENT INFORMED CONSENT FORM FOR OPERATION OR SPECIAL PROCEDURE

1. I hereby authorize Doctor _____ (and other such physician(s) at the Retinal Ambulatory Surgery Center of New York as he/she may designate) to perform upon _____ the following operation(s).

   _____

   _____.
2. Any tissue surgically removed may be examined and retained by the Retinal Ambulatory Surgery Center of New York for medical, scientific, or educational purposes and such tissues or parts may be disposed of in accordance with accustomed practice and applicable State laws and regulations.
3. The nature and purpose of the operation/procedure, possible alternative methods of treatment, the expected benefits and complications, any associated discomforts and the risks involved have been fully explained to me.
4. I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.
5. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.
6. It is the policy of the Retinal Ambulatory Surgery Center of New York to not accept Advance Directives unless the proxy contains restrictions on resuscitation efforts during your care or at our center. If you provide a copy of your Advanced Directive to the Retinal Ambulatory Surgery Center, the document will be placed in the Medical Record. You certainly have the right to discuss this with your physician.
7. I have been informed of the availability of safe keeping of valuables and I understand that the Retinal Ambulatory Surgery Center of New York cannot accept responsibility for the loss of money or valuables kept in my locker.
8. I authorize the release of all medical information necessary to process the claim for the above dated surgery and request payment of Medicare, Medicaid and/or other insurance benefits made directly to the Retinal Ambulatory Surgery Center of New York and/or the Department of Anesthesia. I understand that I am responsible for any unpaid amount.
9. I am aware that Closed circuit TV's are used for surveillance in public areas of the facility for safety and quality assurance purposes.
10. Your surgery may be recorded for educational purposes only with consent from your doctor and you.
11. Doctors will attend to your problems in the way they feel best to address encountered problems in a way perhaps not planned or discussed previously.
12. Medications or devices may be required to be used in off-label fashion as seen fit by your surgeon. These may be made in pharmacy or drug companies that are not FDA approved. They are being used for your benefit at the discretion of your physician.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO OPERATION THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, AND THAT ALL THE BLANK SPACES ABOVE HAVE BEEN COMPLETED PRIOR TO MY SIGNING:

Patient/Relative/Guardian: _____ Date: _____Time:_____ AM/PM

Relationship, if other than patient signed: _____ Date: _____

Interpreter, if required: _____ Date: _____

Witness: _____ Date: _____

***The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or otherwise incompetent to sign.**

PHYSICIAN'S CERTIFICATION

I hereby certify that we have explained to the patient the nature, purpose, benefits, risks of and alternatives to the proposed procedure and anesthesia plan, have offered to answer any questions and have fully answered such questions. We believe that the patient (relative/guardian) fully understands what we have explained and answered.

_____ _____ _____

Physician's Signature | Print Physician's Name | Date

Rev. 8/19