HENDRICKSON AND HUNT
Pain Management Physicians

Authorization for the Consent to Diagnostic or Therapeutic Procedures and Administration of Anesthetic

Patient name: _____

I authorize and direct my physician, **Jay A. Hendrickson, M.D./ B. Kelly Hunt, M.D.**, to perform the following operation and / or diagnostic procedure:

_____

_____

and / or such other operation(s) or any other therapeutic procedures(s) which may be deemed necessary or advisable, including, but not limited to, the performance of services involving pathology and radiology. Upon my authorization and consent, the above operation, diagnostic procedure, or therapeutic procedure will be performed by Jay A. Hendrickson, M.D./ B. Kelly Hunt, M.D. and or other physician, surgeon or qualified person(s) appointed by him. I understand and agree that the person(s) in attendance for the purpose of administering anesthesia or performing other specialized professional services, such as radiology, pathology and the like, are independent contractors and are not employees or agents of the facility or of my physician or surgeon.

I understand the nature of the operation or procedure, the expected benefits or effects of such operation or procedure and the medically acceptable alternative procedures or treatments. I further understand that these surgical operations, diagnostic procedures, or therapeutic procedures, all may involve calculated risks or complications increased pain, paralysis, bleeding, infection and even death. I have a general understanding of the operation or procedure to be performed on me and that no warranty or guarantee has been made as to the result or cure.

CONSENT TO TEST FOR BLOOD-BORNE DISEASES
I understand that it may be necessary to test my blood while I am a patient of Hendrickson & Hunt Pain Management, in an effort to protect against possible transmission of blood-borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome. If, for example, an employee is stuck by a needle after giving an injection, starting an intravenous fluid, or drawing blood. I understand that my blood as well as the employee's blood will be tested. I have been informed that the performance and results of the HIV antibody test are considered confidential. That the test results in my health record shall not be released without my written permission, except to the individuals and organizations that have been given access by law who are required to keep my health record information confidential.

PATIENT VALUABLE / PERSONAL PROPERTY
I have been instructed to leave VALUABLES at home or place them in the care of family members. I understand that Jay A. Hendrickson, M.D. / B. Kelly Hunt, M.D. is not responsible for lost or damaged personal property such as glasses, contact lenses, hearing aids, dentures, jewelry, coats, and / or money.

CONSENT TO TRANSFER – IN OFFICE
I understand the procedure to be performed on me in this office. If Jay A. Hendrickson, M.D. / B. Kelly Hunt, M.D. shall find it necessary and advisable to transfer me from the office to a hospital or other health care facility, I consent and authorize Dr. Hendrickson/Dr. Hunt or his representatives to arrange for transfer.

Initials: _____

Patient Name: _____

PAYMENT OBLIGATIONS
The patient authorizes payment of his / her insurance benefits to Jay A. Hendrickson, M.D./ B. Kelly Hunt, M.D., The patient also authorizes payment of any account owed by the patient to Jay A. Hendrickson, M.D./ B. Kelly Hunt, M.D., out of insurance benefits, with any balance of the said benefits to be paid to the order of the patient. The patient understands that he / she is financially responsible to Jay A. Hendrickson, M.D. / B. Kelly Hunt, M.D., for charges not covered by any insurance company or any other Third Party. Patient hereby specifically agrees to pay to Jay A. Hendrickson, M.D./ B. Kelly Hunt, M.D., the patient's outstanding balance at the time of discharge and in accordance with the terms and rates then in effect. The undersigned also acknowledges that they are jointly and separately liable for any and all amounts due and owing as a result of the care rendered by Jay A. Hendrickson, M.D. / B. Kelly Hunt, M.D., on behalf of the patient. I / We the undersigned, agree to pay the cost of collection including a reasonable attorney's fee if this account should be placed with an Attorney for collection suit or otherwise.

RELEASE OF INFORMATION
Jay A. Hendrickson, M.D./ B. Kelly Hunt, M.D., is authorized to disclose any portion of the patient's records to any health facility that will be involved in the patient's care upon release from Jay A. Hendrickson, M. D./ B. Kelly Hunt, M.D., and to any entity which may be responsible for payment of the patient's account. The patient and /or the undersigned furthermore authorizes the release of information needed for any claim to the Social Security Administration, this State, and any other entity or insurance company.

OBSERVATION CONSENT
I consent to the photography and / or videos of the operation, for medical, scientific or educational purposes, provided the pictures or descriptive text accompanying them does not reveal my identity.

OWNERSHIP INTEREST
I understand that Dr. Jay Hendrickson and Dr. B. Kelly Hunt have an ownership interest in the Folsom Surgery Center and the South Placer Surgery Center.

CERTIFICATION
The undersigned certifies that he / she has read and understood the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this agreement and consent to and accept its terms.

The answers I have given to all questions are true to the best of my knowledge and I have not withheld information.

Following the procedure / surgery I will have a responsible person drive me home and I have made arrangements for this. I realize that impairment of full mental alertness may persist for several hours following the administration of anesthesia and I will avoid making decisions or taking part in activities, which depend upon full concentration or judgement during that period.

Written instructions have been explained and a copy has been given to me.

_____
Patient / Parent / Guardian Signature

(If patient is a minor or unable to complete the following)
The patient is a minor or unable to sign because:

_____

_____ _____ _____
Witness *Date* *Time*