PHILADELPHIA SURGI-CENTER
9500 Roosevelt Boulevard, Philadelphia, PA 19115
CONSENT FOR SURGERY AT PHILADELPHIA SURGI-CENTER

(Patient name) _____ is scheduled for the following surgical and/or medical procedures:

_____

_____

Surgeon: ***Dr. Raphael Gabay*** Asst. Surgeon: _____

The advantages, disadvantages and alternatives to the above procedure(s) have been explained to me in terms that I understand. I realize that following my operation, admission to a hospital might be necessary. I agree to be admitted to ARIA HEALTHCARE SYSTEMS, TORRESDALE DIVISION (or St. Christopher's Hospital for children) if my doctor decides it is necessary. I further acknowledge that no guarantee or assurance has been made as to the results that may be obtained from my surgery.

I realize that following the administration of medication or anesthesia, my mental alertness may be impaired for several hours. I will not make any decisions or participate in any activities that depend on full mental alertness during that time. I will not drive a vehicle or operate dangerous machinery during that time.

I understand that photography is important in planning and evaluating some surgical procedures and I give permission for photographs to be taken before, during and after my surgery, should my doctor deem it necessary. These photographs will be used for the purpose of documentation only.

I consent to the disposal of any tissue that is removed surgically. I authorize ***Dr. Gabay*** to send any specimen(s) taken from my body to a pathology lab for testing.

If appropriate, I have made arrangements for the full payment of monies due prior to this procedure. If my procedure is covered by insurance, I agree to be responsible for the "balance due" once insurance has been paid.

I am taking the following medications: _____

_____

I have the following allergies & reactions: _____

_____

To the best of my knowledge, all of the answers to the questions I have been asked are true and I have not withheld any information.

The Risks, Benefits and Alternatives of an Ambulatory Surgical Facility have been explained to me. I understand that all physicians at the Philadelphia Surgi-Center have varying degrees of financial interest in the facility and they have offered me an alternate site for the procedure..

I have had the opportunity to ask questions concerning the proposed treatment and my questions have been answered to my satisfaction. Therefore, **I hereby consent to the proposed operation and the administration of the necessary pre-operative, intra-operative, and post-operative medications** at Philadelphia Surgi-Center.

_____ _____

(Signature of PATIENT) *(Signature of WITNESS)*

_____ _____

(Signature of AUTHORIZED REPRESENTATIVE) *(RELATIONSHIP to Patient)*

_____

Signature of PHYSICIAN)

Date: _____ Time: _____am/pm