THE SURGICAL SUITES, LLC
1100 WARD AVENUE, SUITE 1001
HONOLULU, HAWAII 96814
TEL: (808) 531-0127 FAX: (808) 531-0455

INFORMATION AND CONSENT: for pre-op, operation, post-op care, medical treatment, anesthesia, or other procedures.

NAME OF PATIENT: _____

INTRODUCTION:

You have the right and obligation to make decisions concerning your health care. Your doctor can provide you with the necessary information and advice, but because this affects you, you must actively participate in the decision making process. This form provides healthcare and consent information. It also requires you to acknowledge your acceptance of treatment(s) recommended by your doctor. Please feel free to ask any questions at any time.

1. AUTHORIZATION:

I hereby authorize **Ming Chen, M.D.** (and any associate or assistant involved in my care) to treat the following condition(s), which has (have) been explained to me.

2. DESCRIPTION OF CONDITION TO BE TREATED

(In professional language):
CATARACT AND POSSIBLE ASTIGMATISM: _____ EYE.

(In ordinary or lay language):
CLOUDED NATURAL LENS AND POSSIBLE IRREGULAR CORNEA SHAPE: _____ EYE.

3. DESCRIPTION OF OPERATION, PROCEDURE OR TREATMENT:

(In professional language):
CATARACT EXTRACTION WITH INTRAOCULAR LENS IMPLANT _____ EYE, AND POSSIBLE LIMBAL RELAXING INCISIONS.

(In ordinary or lay language):
OPERATION TO REMOVE THE CLOUDED NATURAL LENS OF THE _____ EYE AND THE INSERTION OF AN ARTIFICIAL LENS. POSSIBLE CUTS ON YOUR CORNEA IN AN ATTEMPT TO CORRECT IRREGULAR SHAPE.

☐ _____ I understand and acknowledge that the **LenSx® Laser** will be used for my procedure today and that it is indicated for use in patients undergoing cataract surgery for removal of the crystalline lens. The LenSx® Laser may be used in cataract surgery include anterior capsulotomy, phacofragmentation, and the creation of single plane and multi-plane arc cuts/incisions in the cornea, each of which may be performed either individually or consecutively during my procedure. I have discussed the potential benefits, risks, advantages and complications associated with use of the LenSx® Laser with my surgeon and hereby agree to its use.

4. UNFORESEEN CONDITIONS

I understand that during the course of the operation, postoperative care, medical treatment, Anesthesia, or other procedures, unforeseen conditions may necessitate my above named doctor, and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life and bodily functions.

5. RISKS

I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest, and other consequences that can lead to death or permanent or partial disability, which may result from any procedure.

6. NO PROMISE OR GUARANTEE

No promise or guarantee has been made to me as to the result of my care.

NOTE: ANY SECTIONS BELOW, WHICH DO NOT APPLY TO THE PROPOSED TREATMENT, MAY BE CROSSED OUT. ALL SECTIONS CROSSED OUT MUST BE INITIALED BY BOTH THE DOCTOR AND THE PATIENT.

7. ANESTHESIA

I consent to the administration of (general, spinal, regional, local) anesthesia by an anesthesiologist, by my attending physician, or by other qualified individuals under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney. These complications may result in paralysis, cardiac arrest and related consequences, or death from both known and unknown causes.

8. PHYSICIAN OWNERSHIP DISCLOSURE STATEMENT

As you are aware, your Physician has determined that you require further medical treatment and has recommended The Surgical Suites, LLC as your surgical facility. Under Federal CMS requirements, you are hereby notified that your physician, ***(checked here)*** ☐ Dr. Faulkner, ☐ Dr. Jenkins, ☐ Dr. Omphroy, or ☑ Dr. Chen has a financial relationship with The Surgical Suites, LLC. Additionally, there are other facilities in the community where the procedure(s) may be performed. By signing this consent, you acknowledge this disclosure of ownership and wish to be treated at The Surgical Suites, LLC. Additionally, you understand that the Physician who referred you to this facility has a financial relationship with the center and it is your choice to continue with treatment at The Surgical Suites, LLC.

9. ACKNOWLEDGEMENT OF RECEIPT OF ADVANCED PATIENT INFORMATION

I acknowledge that I have received a copy of The Surgical Suites' ① PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES, ② NOTICE OF THE USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION, and ③ HAWAII ADVANCE HEALTH-CARE DIRECTIVE ***(patient check one):***

☐ The required minimum of 24 hours in advance of my scheduled procedure.

☐ Less than the required minimum of 24 hours in advance of my scheduled procedure; however, I understand the rights provided to me in these documents and wish to proceed with my procedure as scheduled.

10. TISSUE DISPOSAL:

Any tissue or parts surgically removed may be disposed of by The Surgical Suites, or the doctor in accordance with accustomed practice.

11. PHOTOGRAPHY AND TELEVISION:

I consent to the photographing, videotaping, television, or other audio or visual recording of this operation, postoperative care, medical treatment, anesthesia, or other procedure for medical or scientific purposes, or for the purpose of advancing medical education, provided my identity is not revealed by the pictures, by the recording, or by the descriptive texts accompanying them.

12. OBSERVERS:

For the purpose of advancing medical education, I consent to the admittance of observers to the operating room during my postoperative care, medical treatment, anesthesia, or other procedures.

13. **DATA FOR RESEARCH:**

I authorize Dr. Ming Chen to use my data for research and keep my identity confidential.

14. ADDITIONAL COMMENTS ☐ Yes, please explain below. ☐ No

15. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS.

☐ Yes, I have no further questions.
☐ No, I have further questions.
☐ Further questions have been answered.

FULL DISCLOSURE

I AGREE THAT MY DOCTOR HAS INFORMED ME OF THE FOLLOWING:

(a) Diagnosis or probable diagnosis;
(b) Nature of the treatment or procedure recommended;
(c) Risks or complications involved in such procedure or treatment;
(d) Alternative forms of treatment available, including non-treatment; and
(e) Anticipated results of the treatment.

I HAVE RECEIVED AND REVIEWED THE ABOVE INFORMATION WITH MY DOCTOR AND UNDERSTAND ITS CONTENT.

Patient or other legally responsible person's signature*	Relationship of authorization person who consented for the patient.	Doctor's Signature	Date

(Below for Office Use Only, to be completed at TSS on date of procedure)

THE SURGICAL SUITES FACILITY

I have read and understand all of the information contained herein. I hereby give my consent, by my signature below.

Patient or other legally responsible person's signature*	Relationship of authorization person who consented for the patient.	Witness's Signature	Date

(*If the patient is a minor, unable to sign, or incompetent to give consent, then, the relationship of person authorized to give consent must be stated.)