**BLUEGRASS EAR, NOSE & THROAT**

**ALBERT SPEACH, M.D.**

# SURGICAL CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Patient:_____DOB:_____

Responsible Party & Relationship to Patient:_____

Procedure:_____

Facility: Kentucky Surgery Center (859)278-1460
Lexington Surgery Center (859)276-2525
St Joseph Hospital (859)313-2133

Scheduled Date:_____(You will be contacted with the exact arrival time the day before your surgery date. Typical arrival times are usually no earlier than 6:30am and no later then 10:30am. If you need to make arrangements for transportation or childcare, you need to plan on the 6:30am arrival time.)

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**PLEASE INITIAL BELOW**

**I. Information Regarding the Procedure**

_____Dr. Speach fully explained the risks/complications of the surgery to be performed on the patient, and by signing my initials I indicate that I understand the possible risks and complications associated with the surgery.

**II. Patient/Guardian Duties and Responsibilities**

_____I understand that if the patient has had any **ASPIRIN, ADVIL, MOTRIN, IBUPROFEN, and/or related ANTI-INFLAMMATORY OR ARTHRITIS MEDICATIONS** within three weeks prior to surgery this greatly increases the risk for bleeding complications. I have informed Dr. Speach if the patient has had any of these medications within the three week time frame so that the patient's surgery may be scheduled at a safe interval from the last date these medications were given. I also understand that the patient is not to have any of these medications up to three weeks after the surgery as well. (The only surgical procedure that is exempt from this protocol is the placement of ear tubes/BMT).

_____I have informed Dr. Speach of the patient's medical history including medical conditions such as diabetes, high blood pressure, bleeding disorders, and/or latex allergies and have also given him a complete list of medications that the patient takes on a daily and/or as needed basis. I understand this information is crucial to the patient's quality of care and that withholding information (either deliberately or mistakenly may put the patient at dangerously higher risk of a bleeding or other complication during surgery or post-operatively.

_____ I have also disclosed to Dr. Speach if the patient has been diagnosed with any blood-borne/infectious diseases such as but not limited to Hepatitis and/or HIV/AIDS. I have also disclosed if the patient is at high-risk for blood-borne/infectious disease including hospital/medical worker, prior blood transfusion, history of IV drug use, and/or homosexual relationship. I understand it is the patient's/guardian's responsibility to inform Dr. Speach of such diagnoses or risk factors for blood-borne/infectious disease and failure to do so (either deliberately or mistakenly) violates the doctor/patient contract

_____I understand that failure to disclose any aspect of my medical history or risk factors for blood-borne disease (either deliberately or mistakenly) may result in the discharge of the patient from Dr. Speach's care.

_____I understand that if I am late for my surgical arrival time the procedure may be cancelled and rescheduled for another date. I understand that surgical dates are in high demand and that repetitive cancellations, failures- to- show, or habitually late arrivals may result in the inability of the surgery to be rescheduled. The only cancellations that do no fall under this protocol would be cancellation by anesthesia or by a physician pending further medical testing for patients who may be at risk for anesthesia complications.

_____I understand that if my appointment is cancelled for any reason, usual protocol requires that the patient have surgery within 30 days of the last office visit with Dr. Speach. If surgery is scheduled outside of 30 days of last office visit, another preoperative appointment and labwork may be required.

**III. Information Regarding Insurance Verification/Coverage**

_____I understand that the person who carries the insurance (Subscriber) for the patient (Patient/Spouse/Parent/Guardian/Foster Parent) is responsible for all deductibles, co-insurance, co-pays, and out-of-pocket expenses related to the surgery. It is my responsibility to provide up-to-date insurance information to the provider and the facility when services are rendered to the patient. Failure to do this may prevent timely filing of insurance claims which may result in non-payment by the insurance company leaving the Subscriber with the balance in full. If I have questions regarding the patient's benefits and for what the Subscriber would be responsible, I may obtain this by calling customer service at the number listed on my insurance card.

_____I understand that the Subscriber is responsible for all charges incurred for the procedure. It is my responsibility to make sure that Dr. Speach and the facility where the procedure is to be performed is in-network with my insurance, and that failure to do so will not release the Subscriber from payment of charges incurred at a higher rate due to out-of-network processing. **Ultimately it is the responsibility of the Subscriber to know the specifics of the patient's insurance plan.** Again, any questions regarding this may be answered by calling the insurance carrier's customer service number.

Signed:_____

for patient (if applicable)_____

Date:_____

Witness:_____