ADVANCED SURGERY CENTER, L.L.C.

CONSENT FOR PERFORMANCE OF OPERATION AND / OR ADMINISTRATION OF ANESTHESIA

ACKNOWLEDGMENT OF INFORMED CONSENT: I have been advised of the procedure, the alternatives, and the risks associate with this operative procedure as well as the risks of anesthesia. I acknowledge that medicine is not an exact science and no guarantees have been made concerning the results. The advantages and disadvantages of outpatient surgery have been explained to me. I realize that following my operation admission to a hospital may be advised. I consent, if in the opinion of my physician such admission should be deemed advisable in my best interest.

ADDITONAL SERVICES: I further consent to the performance of any other operation or procedure preceding, during or following the above mentioned procedure which the physician or surgeon in charge deems necessary or desirable to be performed by himself or his designees in the exercise of professional judgement. This authority shall extend to treating all conditions that require treatment which are not known to the physician or surgeon in charge at the time the operation begins.

ANESTHESIA: I further consent to the administration of such anesthesia as may be considered necessary or desirable in the judgment of the physician in charge of anesthesia or the surgeon in charge. I understand that the administration of an anesthetic involves certain possible risks and complications.

TISSUE DISPOSAL: I further consent to the disposal by the doctor of any tissues or parts which it may be necessary to remove from my said person or body during any of the above mentioned operations or procedures. I also consent to the preservation of such tissue or parts by the doctor for scientific or teaching purposes or for use in grafts upon living persons.

MEDICAL RESEARCH AND EDUCATION: I consent and give my permission for medical data concerning my treatment and operations to be used by the Doctor and other associates working with him in the interest of medical research and education.

OBSERVER AND/OR FILMING: I consent and give my permission to the use of photography and television for family viewing and the presence of medical observers that the Doctor might deem fit to watch my surgery.

LABORATORY TESTING FOR EXPOSURE TO INFECTIONS: In the event of exposure of my bodily fluid(s) or tissue to any individual(s) involved in my care, I consent to having any bodily fluid(s) and/or tissue obtained and submitted for any testing deemed reasonable by my health care providers. I consent to having the results of these tests made available to any health care provider(s) who was or may have been exposed to such fluids and/or tissue.

I certify I have read and fully understand the above consent. The operation has been fully explained by my surgeon, and all my questions have been satisfactorily answered. I authorize and consent to the performance of the operation.

ADVANCED SURGERY CENTER

FINANCIAL AND BUSINESS CONSENT

LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS: I understand that Advanced Surgery Center, LLC are providing the equipment, technical support and staff support to be used in performing this procedure. Further, I understand that the professional services provided in performing this procedure will be supplied by physicians who have been granted privileges to perform this procedure at this facility. I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesiologist, radiologist, or pathologist are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her physician and it is the responsibility of the surgery center and its staff to carry out instructions of the physician. I understand that the physician identified will be assisted by others as he or she considers necessary to my care.

OWNERSHIP OF SURGERY CENTER: I understand that my physician may be an owner of Advanced Surgery Center. I understand that I am free to choose another facility in which to receive the services that have been ordered by my physician.

ADVANCE DIRECTIVE/LIVING WILL: I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the surgery center will still transfer me to the closest hospital which will make decisions about following any advance directive or living will.

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, Advanced Surgery Center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portions of the Center's charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers). I request that payment of authorized Medicare and/or Insurance benefits be made on my behalf to Advanced Surgery Center, L.L.C. for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier where information is needed to determine benefits payable for services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

FINANCIAL AGREEMENT (ANESTHESIA): The undersigned severally agree, whether signing as a patient or otherwise, that in consideration of the services rendered in accordance with the regular rates and terms of the Anesthesia provider listed below. The undersigned clearly understand that the obligation to pay the account is primarily on the patient and the undersigned and while insurance payments received will be applied properly to the patient's account, any part of the account not so paid by the insurance is nevertheless owing and payable. I/We further agree to pay all court and/or reasonable attorney's fees incurred by the Anesthesia provider in enforcing this payment. I consent and agree to authorize the provider of Anesthesia services provided by JOSEPH A. BENDET ANESTHESIA, LLC to release and disclose any personal and medical information to the insurance companies. I also release the provider from all legal liability that may arise from the release of information. I understand that this information is to be released and disclosed only for the purpose of determining the amount payable for all services rendered. Extended payment request (one time authorization): I hereby authorize payment directly to JOSEPH A. BENDET ANESTHESIA, LLC for the anesthesia benefits, otherwise payable to be but to exceed the anesthesiology regular charges for this period of inpatient/outpatient anesthesia consultation fee and for any other period of consultation. In some instances Medicare does not consider anesthesia services "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that your particular service that would otherwise be covered, is not "reasonable and necessary" under Medicare standards, Medicare will deny payment for that service. In instances where Medicare denies payment for any anesthesia service rendered, I agree to be personally and fully responsible for payment.

PATIENT PRIVACY, RIGHTS AND RESPONSIBLITIES: I have been offered a copy of the Privacy Notice and the Patient Rights and Responsibilities. I know to whom I can express suggestions or complaints.