Mazen Hashisho, MD

Vascular, General and Thoracic Surgeon with triple board certification from the
American Board of Surgery and American Board of Thoracic Surgery

CONDITIONS OF ADMISSION

CONSENT TO PROCEDURES

I consent to the procedures which may be performed during my admission to this outpatient center, including emergency treatment or services, laboratory procedures, diagnostic procedures, x-ray examinations, medical, nursing, or surgical treatment or procedures, anesthesia, or center services rendered to me as ordered by my physician or other healthcare professional on the centers medical staff. I understand that the practice of medicine is not an exact science and that the diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment.

CONSENT TO TEST FOR BLOOD-BORNE DISEASES

I understand that it may be necessary to test my blood for blood borne diseases while I am a patient at Pedes Orange County if an employee or independent contractor is stuck by a needle that was used during my treatment. 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 and 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.

TISSUE DISPOSAL

I hereby authorize the physician to use his or her judgement regarding the disposal of any tissue or organ removed from me during my operation or procedure.

PATIENT VALUABLES/BELONGINGS

I have been instructed to leave valuables/belongings at home or place them in the care of family members. I understand that the center is not responsible for lost or damaged personal property such as glasses, contact lenses, hearing aids, dentures, jewelry, coats, or money.

ASSIGNMENT OF BENEFITS

I assign and authorize direct payment to Pedes Orange County and Exper-tech, Inc. for all insurance and health plan benefits payable for services provided. I understand and agree that payment to Pedes Orange County and Exper-tech pursuant to this assignment authorization by my insurance company shall discharge said insurance company of any and all obligations under my policy to the extent of such payment. I agree that I am financially responsible for all charges not paid by my insurance company, to the extent permitted by state and federal law.

OWNERSHIP DISCLOSURE

Each of the physicians listed, or someone in his or her immediate family, has a "significant beneficial interest" as defined by California Business and Professions Code 654.3, in Monterey Bay Vascular (MBV).

We encourage our patients to discuss any concerns they have with us at the time of your visit. Please advise your treating physician if you prefer to be referred to another vascular clinic.

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PATIENTS FREEDOM OF CHOICE

You are free to choose any doctor or facility you wish for obtaining services that may be ordered or requested for you by any physician. This choice however may be affected by restrictions imposed by your insurance plan. Your doctor would be happy to discuss alternatives with you. Potential sources of information concerning alternatives can be obtained by the internet, your insurance company, or the county medical association.

The following address is provided for the filing of any complaints relevant to this notice or the services provided:

•Medical Board of California: 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815

ADVANCE DIRECTIVES

An Advance Directive is a document or documentation allowing a person to give direction about future medical care or to designate another person to make medical decisions if the individual loses decision-making capability. Patients are not required to have an Advance Directive in order to receive treatment at the center.

There are many types of Advance Directives, but the two most common forms are:

•Living Wills – instructions explaining your wishes regarding health care should the individual be unable to make decisions.

•Durable Power of Attorney – A signed, dated, and witnessed document naming another person as an individual's agent or proxy to make medical decisions for that individual should they become unable to make decisions.

The type of Advance Directives that may apply to the center are called "requests to forego resuscitative measures" or "do not resuscitate orders (collectively referred to as a DNR)". A DNR order is typically used by terminally ill patients who do not want to be resuscitated should they suffer a cardiac or respiratory arrest or another life-threatening situation. This center is an outpatient facility where only elective surgery and/or procedures are performed. If a patient should suffer cardiac or respiratory arrest, or any other life-threatening situation, this signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it **WILL NOT** honor previously signed advance directives. If you disagree you must address this issue with your physician prior to signing this form. If you would like a copy of the official state advance directive forms you may download them from: www.calhealth.org or go directly to https://www.calhospital.org/resource/advance-health-care-directive or https://oag.ca.gov/sites/all/files/agweb/pdfs/consumers/ProbateCodeAdvancedHealthCareDirectiveForm-fillable.pdf

CONSENT TO RESUSCITATE AND TRANSFER

Do not resuscitate (DNR) directives ARE NOT honored at this center.

If I should suffer a life-threatening situation during my admission at the center, I authorize the center to initiate resuscitation and continue resuscitation techniques until such time I am transferred to the local acute care hospital. The center will perform necessary life saving measures for all patients until the patient is transferred to the hospital; should such methods become necessary during treatment at the center. I understand that the surgical and/or diagnostic

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procedure to be performed on me at this center will be done on an outpatient basis and that the facility does not provide for 24hour patient care. If my attending physician or any other duly qualified physician in his/her absence find it necessary or advisable to transfer me from this facility to a center or other health care facility I consent and authorize the employees of the facility to arrange for the transfer.

PHOTOGRAPHY CONSENT

I consent to be photographed and authorize the use or disclosure of such photographs(s) in order to assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals. I hereby waive any right to compensation for such uses. I and my successors hold the center, its employees, my physician(s)m and any other person participating in my care and their successors from any claim for injury or compensation resulting from the activities authorized by this agreement.

OBSERVER CONSENT

I consent to an observer in the operating room for medical, scientific, or education purposes, provided my identity is not revealed to the observer.