Performance Surgery Center, LLC
1084 Main Avenue, 2nd Floor, Clifton, NJ 07011
Phone: 973-574-3520

PATIENT CONSENT FOR TREATMENT **Patient Label**

I hereby authorize **Performance Surgery Center, LLC,** including its attending physicians, licensed anesthesia providers, registered nurses, and other credentialed clinical and administrative staff, to perform medical evaluations, diagnostic tests, treatment, and procedures as deemed necessary for my care. This consent includes, but is not limited to, laboratory testing, medication administration, anesthesia services, and any other therapeutic or diagnostic interventions determined appropriate by the medical team.

I understand and acknowledge the following:

- I am voluntarily consenting to treatment and understand that I may refuse or withdraw consent at any time prior to treatment.

- The nature, purpose, and potential risks of the proposed treatment and procedures have been explained to me to my satisfaction.

- No guarantees or assurances have been made as to the results or outcomes of my treatment.

- All care will be provided by appropriately licensed and credentialed personnel in accordance with facility policy, applicable state and federal regulations, and standards of clinical practice.

- I have had the opportunity to ask questions and have received answers to my satisfaction.

- My health information may be used and disclosed for purposes of treatment, payment, and healthcare operations, in accordance with HIPAA regulations.

EMERGENCY MEDICAL TRANSFER AUTHORIZATION

In the event of a medical emergency, I authorize **the Performance Surgery Center, LLC** to initiate transfer to an appropriate hospital and to release relevant medical information to ensure safe and effective continuity of care.

PHOTOGRAPHY CONSENT (IF APPLICABLE)

I consent to the use of clinical photographs for documentation and treatment purposes:

☐ Yes ☐ No

ACKNOWLEDGMENT OF RIGHTS & PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Patient Rights and Responsibilities and the Notice of Privacy Practices.

Signature of Patient or Legal Representative: _____

Printed Name: _____ Date: _____

Signature of Witness: _____ Date: _____