

Consent to Operations, Procedures and Other Treatments



Patient's Name: _____

DOB: _____

Initial _____ It is very important to Blossom Bariatrics/Blossom Medical Group that you understand and consent to the treatment your doctor is rendering and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended. Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial on the line provided to the left of the paragraph indicating your understand this paragraph.

I, _____, hereby authorize Dr. Thomas Umbach and any associates or assistants the doctor deems appropriate to perform:

- Upper Endoscopy with possible Biopsy
- Laparoscopic Hernia Repair
- Laparoscopic Liver Biopsy
- Laparoscopic Inguinal Hernia Repair
- Other: _____

The doctor has explained the benefits of the procedure(s) to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s). I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, but not limited to, blood loss, transfusion reactions, infection, heart complications, blood clots, or loss of use of body part (partial or whole), other neurological injury and/or death. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other diseases.

In permitting my doctor to perform the procedure(s), I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his assistants, or his designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event that one or more of the above inherent complications may occur, my physician(s) will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

The reasonable alternative(s) to the procedure(s) have been explained to me. These alternatives include, but are not limited to:

Consent for Testing

I authorize Dr. Thomas Umbach and any associates or assistants the doctor deems appropriate to perform testing and pathology of tissue samples obtained during my procedure.

I understand that there may be additional fees for these tests, but I am confident that my surgeon feels they are necessary to rule out possible complications.

Biopsies that may be tested include but are not limited to liver, stomach, and esophageal. My surgeon will also repair a hiatal hernia if it is discovered that I have a need to complete my operation for minimal obstacles. In the instance that the gall bladder or appendix need attention, my surgeon has my permission to conduct necessary procedures. I further understand any abnormalities will be tested for complete care.

The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, but not limited to, blood loss, transfusion reactions, infection, heart complications, blood clots, or loss of use of body part (partial or whole), other neurological injury and/or death. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other diseases.

In permitting my doctor to perform the procedure(s), I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his assistants, or his designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event that one or more of the above inherent complications may occur, my physician(s) will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

I hereby authorize Blossom Bariatrics and/or Blossom Medical Group to utilize or dispose of removed tissues, parts or organs resulting for the procedure(s) authorized above. I also acknowledge that I will be responsible for additional fees related to these procedures.

By signing below, I certify that I have had an opportunity to ask my doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction

I consent to any photographing or videotaping of the procedure(s) that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them, so that my physician may follow my therapy progression. I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education of obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction. **I have been informed that I must have a driver the day of the procedure.**

Signature: _____ Date: _____



Mutual Binding Arbitration Agreement

Patient's Name: _____

This mutual binding Arbitration Agreement constitutes an integral part of a contract for medical services by and between **Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center** and Patient who agree to be bound as described hereunder:

1. Any dispute, claim or controversy arising out of or relating to any Consent for Treatment or Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this Arbitration Agreement, shall be determined by arbitration in Clark County, Nevada before one arbitrator with at least 10 years of active litigation experience, unless otherwise directed herein. If the amount claimed is less than \$250,000, the arbitration will be administered by JAMS in accordance with JAMS' Streamlined Arbitration Rules and Procedures. Claims brought under the Streamlined rules will have the damages capped at \$250,000. For claims in excess of \$250,000, the Comprehensive Arbitration Rules and Procedures will apply.

2. This Arbitration Agreement expressly applies to any claims for medical malpractice as defined by Nevada law. Any medical malpractice claims must be arbitrated before a panel of three arbitrators. NRS 41A will apply to any such arbitration proceedings, with the arbitration panel taking the place and stead of the district court. NRS 41A.071 specifically applies to any arbitration proceeding, which requires a malpractice claim to be filed with an affidavit supporting the claims by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice of Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Within 15 days after the commencement of arbitration, each party shall select one person to act as arbitrator. The parties will communicate their selected arbitrator to the JAMS Case Manager. If a party fails to select an arbitrator within 15 days, JAMS will appoint an arbitrator. The two party-determined arbitrators will select a third arbitrator to serve as panel chair within 30 days of the commencement of the arbitration. The panel must be chaired by an attorney with at least 20 years of active litigation experience or a retired judge from a court having jurisdiction in Nevada. If the arbitrators selected by the parties are unable or fail to agree upon the third arbitrator within the allotted time, the third arbitrator shall be appointed by JAMS in accordance with its rules and the criteria set forth above. All arbitrators shall serve as neutral, independent, and impartial arbitrators.

3. This Arbitration Agreement applies to any claim against Dr. Thomas W. Umbach individually, Blossom Bariatrics and/or Blossom Medical Group, and/or Warm Springs Surgical Center, and/or any employees or contracted staff. This Arbitration Agreement and the rights of the parties in relation to any claims shall be governed by and construed in accordance with the laws of the State of Nevada.

4. Judgment on the arbitration award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction.

5. The execution of this Mutual Binding Arbitration Agreement shall not be a precondition of the furnishing of medical services by Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or Patient's legal representative within 30 days of signature.

6. The Arbitration Agreement shall bind the parties hereto, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns. All parties to the arbitration will bear their own attorney's fees and costs, and an equal share of the arbitration fees.

Printed Name: _____

Signature: _____ **Date:** _____

(patient/parent/legal guardian/legal representative)

If signed by other than patient, indicate relationship: _____

Assignment of Insurance Payments

Blossom Bariatrics/Blossom Medical Group bills your insurance as a courtesy for all in network and out of network policies. Occasionally the insurance company will send payment directly to the patient. If this does happen with your policy, simply sign the check "Pay to the order of Blossom Bariatrics" then you sign underneath. Be sure to send a copy of all correspondence that comes with it as well.

I understand and acknowledge that I have a legal obligation to pay for the services I have received or will receive from Blossom Bariatrics/Blossom Medical Group.

I also acknowledge that if my health insurance company covers the medical procedures I have received or will be receiving, that payment from my health insurance company should be paid to Blossom Bariatrics/Blossom Medical Group. ***Under no circumstances am I entitled to receive and keep any payments from my health insurance company. These payments are rightfully owed to Blossom Bariatrics/Blossom Medical Group in payment for the services I have received from them.***

THEREFORE, I hereby assign to Blossom Bariatrics/Blossom Medical Group any and all sums of money which I have received to date or which I may receive in the future from my health insurance company.

I HEREBY authorize and instruct _____

Insurance Company, Policy # _____ to pay all sums which it has paid or would pay to me directly to Blossom Bariatrics/Blossom Medical Group at the following address:

Blossom Bariatrics
7385 S. Pecos Rd.
Suite 101
Las Vegas, NV 89120

This Assignment is to remain in full force and effect for all claims submitted and all payments made from the date this Assignment is executed below until it is revoked in writing.

Signature: _____ Date: _____

Printed Name: _____

Blossom Witness Signature: _____

Blossom Printed Name: _____ Date: _____