Georgetown University Hospital
3800 Reservoir Road
Washington, DC 20007-

(202) 444-2000

Patient: **LEE, JONG HYUN HYUN HYUN**
MRN: GUH-000002380178
FIN: GUH-07731762576
DOB/Age/Sex: 6/1/1993 32 years Male

Date of Service: 5/24/2024
Attending Provider: Rahman,MD,Sabrina

Patient Viewable Documents

MedStar Health

- ☐ MedStar Franklin Square Medical Center
- ☐ MedStar Georgetown University Hospital
- ☐ MedStar Good Samaritan Hospital
- ☐ MedStar Harbor Hospital
- ☐ MedStar National Rehabilitation Hospital
- ☐ MedStar Union Memorial Hospital
- ☐ MedStar Washington Hospital Center
- ☐ MedStar Montgomery Medical Center
- ☐ MedStar Southern Maryland Hospital Center
- ☐ MedStar St. Mary's Hospital
- ☐ MedStar Ambulatory Services
- ☐ MedStar Health Home Care
- ☐ MedStar Health Physical Therapy: _____ location
- ☐ MedStar Medical Group: _____ location
- ☐ MedStar Health Urgent Care: _____ location

LEE , JONG HYUN

7731762576

06/01/1993

2380178 PATIENT LABEL

ENTITY GENERAL CONSENT FORM

MS 102600 (approved 10/13/23)

What Is This Consent For?

- I understand that I am allowing my care team, including clinical providers of the MedStar healthcare entity indicated above, to examine, treat and otherwise care for me, including by a secure telehealth platform.
- I understand resident physicians, medical students, clinical observers, and/or other health professionals in-training may observe or participate in my care under proper supervision.
- I understand that I may always refuse any treatment, test, or procedure.
- I understand that I may always ask questions about my treatment or condition.
- I understand that clinical photography/recording may be included with my treatment.
- I understand and permit a blood sample to be drawn to test for any infection which could be passed on to my care team if the care team member is exposed to my blood or other bodily fluid.
- I understand that if I need a procedure or want to join a research study, I will have to complete another consent form that is for the procedure or study.
- I understand that not all clinical providers are employees, servants, or agents of the MedStar healthcare entity indicated above. Rather, some are independent clinical providers who have been granted the privilege of using a MedStar facility.
- I understand that the MedStar healthcare entity indicated above is not liable for the care and treatment of these independent clinical providers.
- I understand that if it is important to me to know whether my clinical provider is an employee of the MedStar healthcare entity indicated above, I may inquire about their status.
- I understand the MedStar healthcare entity is not responsible for loss of information due to technical failures during telehealth care.
- I consent to the MedStar healthcare entity indicated above to contact me by phone, cell phone, SMS/text message, mail and/or email on my account. I understand I have the right to opt out of receiving SMS/text messages.

About My Financial Responsibilities. I understand that I am financially responsible for my bill in the event my insurance does not pay in its entirety or I am uninsured. I will be appropriately charged even if I leave before my visit is complete.

- **"Assignments of Benefits."** I understand and authorize any insurance payments (whether Medicare, Medicaid, or any other company) to be made directly to the MedStar healthcare entity indicated above and applied to my bill.
- **Provider Charges.** I understand I may also receive separate bills from the provider(s) involved in my care, including those providing consultation during my visit, or from third parties performing services, including outside reference laboratories.
- **My Ability to Pay.** I understand that payment plans are available based on my financial needs.
- Financial Assistance is also available for those that qualify for free or reduced care.
- If my bill goes to collections, I understand that I may also be responsible for those fees if a judgment is obtained.

About My Personal Information. I understand that the MedStar healthcare entity indicated above may release my final diagnosis and other medical information for the purpose of continuing my treatment, determining any payment, or assisting healthcare operations.

About My Valuables. I understand that the MedStar healthcare entity indicated above is not responsible for any loss or damage to my property. I have been advised that if possible, I should leave all money and valuables at home or with a friend or family member.

This form needs to be signed for each ED visit, hospital/facility-based service, including inpatient admissions, urgent care visit, and ambulatory surgery; annually for all other visits.

MS102600

LEE , JONG HYUN

ACCT: 7731762576 DOB: 06/01/1993 A/S: 30M

MRN: 2380178 Reg DateTime: 05/24/24 16:17

Att Md: UNASSIGNED, UNASSIGN

MedStar Health

- ☐ MedStar Franklin Square Medical Center
- ☐ MedStar Georgetown University Hospital
- ☐ MedStar Good Samaritan Hospital
- ☐ MedStar Harbor Hospital
- ☐ MedStar National Rehabilitation Hospital
- ☐ MedStar Union Memorial Hospital
- ☐ MedStar Washington Hospital Center
- ☐ MedStar Montgomery Medical Center
- ☐ MedStar Southern Maryland Hospital Center
- ☐ MedStar St. Mary's Hospital
- ☐ MedStar Ambulatory Services
- ☐ MedStar Health Home Care
- ☐ MedStar Health Physical Therapy: _____ location
- ☐ MedStar Medical Group: _____ location
- ☐ MedStar Health Urgent Care: _____ location

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I have also received the following documents, and they have been explained to me.

- Patient Rights and Responsibilities — JHL Initials
- Notice of Privacy Practices — JHL Initials
- Notice of the Financial Assistance Policy — JHL Initials
- I have an Advance Directive (Living Will) — ☐ Yes ☑ No
  *If a copy is not in your record, please bring a copy to your next visit.
- Do you want information about Advance Directives or appointing a Health Care Agent? ☐ Yes ☐ No

I understand and agree to the contents of this form. If I have question on the above documents, I will speak to a member of my care team.

JA
Signature of Patient or Patient Representative

May 24, 2024 (4:19PM ET)
Date/Time

Printed Name of Patient Representative (if applicable)

Personal Representative Relationship to Patient (if applicable)

If patient unable to sign AND healthcare agent or surrogate not available, attempt telephone consent.

Receipt of Entity General Consent via Telephone

Name of Patient or Representative Providing Telephone Consent: _____
Printed Name

Relationship to Patient: _____
Printed Relationship

Associate Obtaining Telephone Consent: _____
Printed Name

_____
Date

***MedStar Healthcare Entity Associate Section:**

Complete this section if patient representative or telephone consent obtained to indicate reason patient did not sign form.

Check only one:

- ☐ Emergency Patient
- ☐ Clinical team concern for capacity
- ☐ No representative information available
- ☐ Direct Admit/Transfer
- ☐ Physical impairment
- ☐ Other (please specify)_____
- ☐ Incapacitated

Associate Initials:_____

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LEE , JONG HYUN
ACCT: **7731762576** **DOB: 06/01/1993** **A/S: 30M**
MRN: **2380178** Reg DateTime: **05/24/24 16:17**
Att Md: **UNASSIGNED, UNASSIGN**

Lee, Jong Hyun
7731762576

MedStar Georgetown
University Hospital

06/01/1993
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CONSENT FOR SURGERY, ANESTHETICS, AND OTHER MEDICAL SERVICES

1. I hereby authorize Dr.(s) Bryce Davidson, Patricia Timothee
(the primary surgeon(s)/practitioner(s)) and whomever he/she may designate as his/her assistants to perform upon _____ (patient name) the following surgical, medical or diagnostic procedure(s): (physician(s) to state the specific procedure to be performed) _____
Peritonsillar Abscess drainage (Right)
2. I acknowledge that my physician(s) discussed with me the proposed care, treatment and services. I have been advised of the potential benefits, risks, side effects and likelihood of achieving goals. I also have been advised of any potential problems that might occur during recuperation. I have been advised of reasonable alternatives to proposed care, treatment, services and risks, benefits and side effects related to the alternative treatment and the risk related to not receiving the proposed care, treatment and services. I understand that in the course of the procedure the physician(s) may determine that procedures in addition or different from this procedure may be necessary to my well being and that it would not be practical to obtain further consent at the time. I therefore authorize the doctor(s) to perform such procedures without further consultation with me.
3. I have been provided information that in certain circumstances information about my care, treatment and services may be disclosed as required by law or regulation. Certain circumstances may include mandatory reporting requirements to the centers for Disease Control, health department or Food and Drug Administration.
4. My physician, the responsible physician(s), will be present for all critical parts of the procedure even in the event of overlapping procedures (see reverse, if applicable). Other medical professionals may perform some non-critical aspects of the procedure as my responsible physician deems appropriate. I understand that MedStar is a teaching organization. This means that resident doctors, doctors in medical fellowship (fellows) and students in medical, nursing and related health care professions receive training here, and may take part in my procedure, under the oversight and supervision of the responsible physician.
5. I also consent to the administration of anesthetics by or under the direction of the physician that has been trained to perform the required local anesthetic or moderate or deep sedation. The physician has explained the risks, benefits, side effects, and alternatives of the intended anesthesia.
6. For purposes of research, medical education or documentation of my medical condition in the medical record, I consent to the taking of photographs or films during the course of the procedure(s). I understand that my identity will not be revealed if the photographs or films are used for medical education or research, and in all instances patient confidentiality will be preserved. I understand that copies of the prints will be given to me if I ask for them.
7. I am aware that the practice of medicine and surgery is not an exact science, that there is no certainty that the desired benefits will be achieved and I acknowledge that no guarantees or assurances have been made to me concerning the outcome.

Jong Hyun Lee	May 25 2024	12:38 AM	Self
Patient or authorized representative signature	Date	Time	Relation to Patient
WOODBURY	5/25/24	0038	
Witness signature	Date	Time	

VERBAL TELEPHONE CONSENT
(If authorized representative is not available to sign the above consent)

Authorized Representative Name			Relation to Patient
Signature of Physician/ Practitioner Obtaining Consent	Date	Time	
Signature of Witness to Verbal Consent	Date	Time	

☐ **NON-OR SAFE SURGERY CHECKLIST:**
Team Pause Date: _____ Time: _____ Signature & Title _____
☐ Patient receiving anticoagulation: ☐ Yes ☐ No ☐ Coagulation abnormalities addressed: ☐ Yes ☐ No
☐ Correct Patient Identity ☐ Agreement on Procedure to be Done.
☐ Correct Site & Side Marked: ☐ Left ☐ Right ☐ N/A
☐ Correct Patient Position ☐ Availability of All Anticipated Equipment, Meds and/or Supplies
☐ Patient History Checked

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Lee, Jong Hyun *Page 1 of 2*
ACCT: **7731762576** DOB: **06/01/1993** A/S: **30M**
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Att Md: **Rahman, MD, Sabrina**

Page 1 of 2

Additional Information for Overlapping Procedures

What is an Overlapping Procedure?
An overlapping procedure is the practice of the surgical team preparing one patient for a procedure in one room while at the same time other team members finish another patient's procedure in a separate room. National studies have found no difference in complications from procedures where overlapping occurs. There are very strict rules that apply; during a overlapping procedure. The responsible physician must complete the key portions of any overlapping procedure.

What to Expect for Your Surgery or Procedure
Your care team is led by your "Responsible Physician". This is the surgeon responsible for your procedure. Your Respon physician:

- Will be in the procedure room for the critical portions of your procedure.
- May not be in the room with your care team for noncritical portions of your procedure.
- Will be immediately available to return to the room and assist your care team if needed.
- Will ensure the team members performing the noncritical portions are qualified and capable of performing their p
- May begin to be involved in the care of another patient before and after the critical portions of your procedure are completed. In this situation, another physician is identified in advance to assist the care team in the rare circumst in which help is needed.
- Will not perform critical portions of a procedure on another patient in another room at the same time as critical pc of your procedure are being completed, except in the case of an emergent or life threatening situation with anoth patient.

In addition to the Responsible Physician, your care team may include the following members: anesthesiologist, certified registered nurse anesthetist, operating room or procedure room nurse, surgical technologist; residents, fellows or medic nursing and related health care professional students, and a physician assistant.

Surrogate Decision Maker / Personal Representative
Priority List for Adult Patients

Following certification of physical or mental incapacity, a surrogate decision maker / personal representative is a person authorized to make healthcare decisions on behalf of another individual by a durable power of attorney for health care (Advance Directive). In the absence of a document naming a surrogate decision maker / personal representative, the following individuals, in the order or priority set forth below, are authorized in the District of Columbia, to grant, refuse or withdraw consent of behalf of the patient with respect to the provision of any health-care service, treatment, or procedure:

1. A court appointed guardian or conservator of the patient.
2. The spouse or domestic partner (any adult living with, but not married to, the patient in a committed intimate relationship, including any adult registered as a domestic partner).
3. An adult child of the patient.
4. A parent of the patient.
5. An adult sibling of the patient.
6. A religious superior of the patient, if the patient is a member of a religious order or a diocesan priest.
7. A close friend of the patient (any adult who has exhibited significant care and concern for the patient, has maintained regular contact with the patient, and is familiar with the patient's activities,health, religious and moral beliefs). The friend may **NOT** be a healthcare provider, an owner, operator, administrator, an employee, of or a person with decision-making authority for, a health-care provider that is providing services to the patient at the time of healthcare decision.
8. The nearest living relative of the patient.

If no individual in the prior class is reasonably available, mentally, capable and willing to act, the responsibility for decision making shall rest with the next reasonably available, mentally capable, and willing person on the priority list.

PLEASE NOTE: The order of priority established above in 3-8 is presumed. However, it can be rebutted if a person of lower priority is found to have better knowledge of the wishes of the patient, or if the wishes of the patient are unknown and cannot be ascertained, is better able to demonstrate a good-faith belief as to the interests of the patient.

Verbal consent by the Surrogate Decision Maker: When the surrogate decision maker is not physically present, the Procedure Practitioner will contact the surrogate decision maker and review the material risks, benefits and alternatives and likely consequences if treated is refused. With the permission of the surrogate decision maker, an individual, will monitor the telephone conversation. The pertinent aspects of the conversation will be recorded in the patient's chart.

If the patient is a minor, or you have other questions, please refer to the details in GUH Policy 117. If there is a question or dispute regarding the priority, contact MedStar Legal Services through the page operator.

Certification of Mental Incapacity: Two physicians, one of whom must be a psychiatrist, must certify in writing in the patient's chart that the patient is incapable of understanding the healthcare choice and making a decision concerning treatment.