Patient Name: _____ Date of Birth: _____

Consent to Medical/Surgical Office Procedure

I (or my authorized representative, i.e., parent or guardian),_____, consent to the medical/surgical treatments (hereinafter collectively referred to as "procedure") outlined below to be performed by_____and their staff, associates, or assistants to whom the provider(s) performing the procedure may assign responsibilities. In the event one or more of the providers is unable to perform or complete the procedure, a qualified substitute provider will perform or complete the procedure.

The proposed medical/surgical procedure is: _____

for the diagnosis/treatment of:_____.

The procedure has been explained to me in terms that I understand. The explanation included:

- The nature and extent of the procedure to be performed.
- The most frequently occurring risks of the procedure involved, and those risks which are unlikely to occur, but which may involve serious consequences, including but not necessarily limited to the following:

_____
_____
_____
_____
_____
_____

- General risks which may include pain, scarring, bleeding and infection.
- The benefits of the procedure.
- The anticipated results of the procedure.
- The estimated period of incapacity or convalescence, if any.
- The risks and benefits of any reasonable alternatives to this procedure including having no procedure at all.

I was given the opportunity to ask any questions I have regarding the procedure and I have had those questions answered to my satisfaction.

I understand that I may consult or could have consulted with another provider about this procedure.

I understand that I have the right to refuse any medical/surgical treatment recommended at any time prior to its performance.

I authorize my provider to perform such additional procedures which in their judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.

If any unforeseen condition arises during this procedure which requires transportation to a hospital, additional procedures, operation or medication including anesthesia and blood transfusions, I further request and authorize my provider to do whatever they deem advisable on my behalf.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure.

Patient Name: _____ Date of Birth: _____

I authorize the provider performing the procedure, or their staff, associate, or assistant to whom the provider may assign the responsibility, to use their discretion in disposing of or using any tissue or body parts that may be removed during the procedure set forth above, subject to the following conditions (if any):

_____.

I authorize that a provider in training may participate in my care; a representative or technician from a medical device company may be present at the procedure; medical photography may be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in the photo or text.

If the provider or any other person caring for me comes into contact with my blood or other body fluids, I agree to have my blood tested for a communicable disease. This includes testing for HIV, hepatitis, and other diseases. I further consent to the release of the results of these blood tests to the exposed persons involved. If disease is found, I will be contacted by my provider to discuss treatment if necessary.

I acknowledge that I have read (or had read to me) and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize my provider to perform the above discussed procedure.

Patient's Signature:_____Date/Time:_____

Parent/Guardian Signature:_____Date/Time:_____

Witness to Signature:_____Date/Time: _____

I verify that I have explained the information contained in this document to the patient or person giving consent. It is my opinion that the person granting consent has fully understood all subjects discussed.

Provider's Signature_____Date/Time:_____