

Consent to Medical/Surgical Office Procedure

Office Practice Name

Address

Telephone

I (or my authorized representative, i.e., parent guardian), _____, consent to the medical/surgical procedures outlined below to be performed by _____ and his/her staff, associates, or assistants to whom the physician(s) performing the procedure may assign designated responsibilities. In the event one or more of the physicians is unable to perform or complete the procedure, a qualified substitute physician 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, include but are not necessarily limited to the following: _____
- General risks which may include pain, scarring, bleeding and infection.
- The benefits 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 treatment 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 physician 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 physician to perform such additional procedures which in his/her 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 physician to do whatever he/she deems 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.

I authorize the physician performing the procedure, or his/her staff, associate, or assistant to whom the physician may assign the responsibility, to use his or her 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 physician 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.

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 physician to perform the above discussed procedure.

Patient Initials. _____/Date_____ (Full signature required below)

Sedative Analgesia [Moderate Sedation; Conscious Sedation]

I understand the administration of sedative analgesia is recommended. The benefit of the sedation is greater comfort throughout the procedure. It has been explained to me that all forms of sedation involve some risks. I understand that no guarantees or promises can be made concerning the results of my procedure or the sedation technique administered. Complications with sedative analgesia can occur and include: inadequate sedation, drug reaction, the possibility of infection, bleeding or injury to blood vessels at the intravenous site. More severe complications could include depression of respiration and heart problems that could lead to serious consequences, including even loss of life. Alternatives to sedation include no sedation at all, and have been explained to me.

I acknowledge that I have read (or had read to me) and understand the above information on sedative analgesia. Furthermore, I certify that all my questions and concerns regarding the administration of conscious sedation, its attendant risks, benefits and alternatives have been explained to my satisfaction. I agree not to drive a car, operate machinery or make any legal decision within 24 hours as the effect of sedation may remain in my system for this period of time. I hereby authorize my physician and/or individuals qualified to do so, to administer this analgesic.

Patient Initials. _____/Date_____ (Full signature required below)

Patient's Signature/Power of Attorney/Guardian

Date of Birth

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.

Physician Signature