Consent to Medical/Surgical Office Procedure

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I (or my authorized representative, i.e., parent guardian),_______________________________, give my permission to Dr.__________________________________and such designees as needed to perform________________________________
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The proposed medical/surgical procedure is for the diagnosis/treatment of ____
The procedure or treatment has been explained to me in terms that I understand. The explanation included:

- The nature, description and extent of the procedure or treatment to be performed.
- The most frequently occurring risks of the procedure or treatment involved, and those specific risks which are unlikely to occur but which may involve serious consequences if any____
- General risks which may include pain, scarring, bleeding and infection.
- The benefits of the procedure.
- The estimated period of incapacity or convalescence, if any with expected recovery signs and symptoms.
- The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all with potential results, outcomes and expectations.

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 or my condition would be cured or improved.

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 for examination and laboratory (pathology) testing.

I agree to used local analgesia as needed. I am aware of the associated risks and complications with analgesia including but not limited to: inadequate analgesia, local and severe (anaphylaxis) drug reaction, the possibility of infection and bleeding. The alternatives to analgesia include no analgesia at all, have been explained to me.

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.

____ **Date:** _____________ **Time:** ____________
Patient's Name and Signature/Power of Attorney/Guardian/Parent/Representative

____ ______________________________
Relationship to the patient if Representative signed the consent **Witness (Optional)**

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____ **Date:** ______________ **Time:** ___________