AMERICAN SURGERY CENTER
CONSENT TO MEDICAL AND SURGICAL PROCEDURES

NAME_____ CENTER #_____

I, _____, hereby consent to the medical/surgical procedures outlined below, to be performed by _____, and his/her associates, assistants and appropriate center personnel. The medical/surgical procedure _____

_____

for the diagnosis/treatment of_____

_____

This procedure has been explained in terms understandable to me, which explanation has included:

1. The nature and extent of the procedure to be performed.
2. Risks involved, including those which, even though unlikely to occur, involve serious consequences.
3. Alternative procedures and methods of treatment.
4. The dangers and probable consequences of such alternative including no procedure or treatment.
5. The expected consequences of the procedure upon my future health.
6. The estimated period of incapacity and the estimated period of convalescence (assuming there are no complications).

I understand that there are other risks, such as the risks of infection and other serious complications, in the pre-operative and post-operative stages of my care, which can result in the loss of the use of parts of my body and life.

I have asked all the questions which I thought were important in deciding whether or not to undergo treatment or diagnosis. Those questions have been answered to my satisfaction.

I understand that no assurance can be given that the procedure will be successful, and no guarantee or warranty of success or cure has been given to me.

I have been advised that I may have anesthesia which may result in nausea, muscular aches, dental damage or which in rare instances has serious and even fatal complications.

I further authorize and request my physician and his/her associates, assistants, and appropriate center personnel to perform such additional procedures which in their judgement are incidentally necessary or appropriate to carry out my diagnosis/treatment.

I authorize the center to dispose of any severed tissue, organs, or body parts in accordance with its policies.

I consent to the photographing or televising of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompany them.

I consent to the administration of blood or blood products as my physician/physicians deem necessary.

I have been afforded the opportunity to consult with other physicians to my complete satisfaction before signing this form, and I understand that I have the right to refuse any medical and surgical procedures and treatment.

I certify that I have read and fully understand the above consent statement, that the explanations therein referred to were made by _____ and are understood by me, that all blanks or statements requiring insertion or completion were filled prior to the time of my signature, and that this consent is given freely, voluntarily, and without reservation.

_____ _____

Patient Signature Date Authorized Person and Relationship

_____ _____

Physician Signature Date Witness to Signature Date