

CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURES

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

Name of Patient: _____ Date: _____

(A) (1) I acknowledge and understand that the following procedure(s) which has (have) been described to me is (are) to be performed on the patient:

and that as a result of the performance of the procedure(s) there is a material risk that the patient may suffer **infection, allergic reaction, severe loss of blood, loss or loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest, or death.**

(2) I acknowledge and understand that during the course of the procedure(s) described in subparagraph (A) (1) above, conditions may develop which may reasonably necessitate an extension of the original procedure(s) or the performance of procedure(s) which are unforeseen or not known to be needed at the time this consent is obtained. I, therefore, consent to and authorize the persons described in the last paragraph of this consent to make the decisions concerning the performance of and to perform such procedure(s) as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

(B) I acknowledge and understand and duly evidence in writing by executing this form that I have been informed in general terms of the following:

- (1) A diagnosis of the condition requiring the procedure(s);
- (2) The nature and purpose of the procedure(s);
- (3) The material risks of the procedure(s) (see paragraph (A) above);
- (4) The likelihood of success of the procedure(s);
- (5) The practical alternatives to such procedure(s); and
- (6) The prognosis if the procedure(s) is (are) rejected.

Informed consent was provided to me through the use of video tapes, pamphlets, booklets, or other means of communication or through conversations with the responsible physician, or other medical personnel under the supervision and control of the responsible physician, other medical personnel involved in the course of treatment, nurses, physician's assistants, trained counselors, or patient educators.

(C) I acknowledge that there are practical alternatives to the procedure(s) described in paragraph (A) which alternatives reasonably prudent physicians generally recognize and accept.

(D) I acknowledge and understand that this request for and consent to surgical or diagnostic services shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the responsible physician, and for all other medical personnel otherwise involved in the course of treatment.

(E) I understand that all physicians providing medical services at Henry Medical Center are not employees or agents of the hospital but are independent professionals engaged in their private practice of medicine.

(F) I also consent that any tissues, specimens, organs or limbs removed from the patient's body in the course of any procedure may be tested or retained for scientific or teaching purpose and then disposed of within the discretion of the physician, hospital or other health care providers.

(G) I consent to the administration of anesthesia as Henry Anesthesia Associates, LLC may deem advisable in my case.

CONTINUED ON BACK OF FORM



STOCKBRIDGE, GEORGIA 30281

(COMPOSITE STATE BOARD OF MEDICAL EXAMINERS PROTOTYPE)

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Witness

Reason patient is unable to sign

Signature of Patient or other person authorized to sign and relationship

Signature of Physician

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS, AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ OR HAD IT READ OR EXPLAINED TO ME AND I UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW DR. _____ OR ANY PHYSICIAN DESIGNATED OR SELECTED BY HIM OR HER AND ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF SUCH PHYSICIAN AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN PERFORMING SUCH PROCEDURES TO PERFORM THE PROCEDURES DESCRIBED OR OTHERWISE REFERRED TO HEREIN.

BEFORE SIGNING YOU MUST READ FRONT AND BACK OF THIS FORM

* (H) I consent to the presence of observers during the surgery or procedure and to the photographing or televising of the same as approved by my physician. * Patient may line through and initial item (H) if consent is not desired.
(I) I consent to release of my social security number to the device manufacturer in the event that the procedure calls for the implantation or removal of a medical device that requires tracking by the FDA (Federal Drug Administration). I release Henry Medical Center from any liability that might result from the release of this information.
(J) I consent to the presence of a healthcare industry representative during my procedure, as deemed necessary by my physician. These representatives are not employees of Henry Medical Center and their roles are very limited. They may be required for technical advisement, delivery of medical devices, equipment, etc.