MEDICAL CONSENT FORM

I. PARTIES AND DATE

This Medical Consent Form (the "Agreement") is entered into on the _____ day of _____, 20____, by and between:

The Patient:

Name: _____

Date of Birth: _____ day of _____, 20____

Address: _____

Phone: _____

AND

The Healthcare Provider/Facility:

Physician/Provider Name: _____

Facility Name: _____

Address: _____

II. DESCRIPTION OF PROCEDURE

The Patient (or the Patient's Legal Guardian) hereby authorizes the Healthcare Provider and such assistants, nurses, and other medical personnel as the Healthcare Provider may deem necessary, to perform the following medical treatment, procedure, or operation (the "Procedure").

The specific nature of the medical treatment, procedure, or operation is:

_____

_____

_____

_____

III. ANESTHESIA AND SEDATION

The Patient understands that the Procedure may require the administration of anesthesia or sedation. The Patient consents to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service.

The Patient authorizes the following types of anesthesia (check all that apply):

☐ Local Anesthesia

☐ General Anesthesia

☐ Intravenous Sedation

☐ Regional Block

☐ As deemed necessary by the Anesthesiologist/Provider

IV. RISKS AND COMPLICATIONS

The Patient acknowledges that the Healthcare Provider has explained the nature, purpose, and reasonably foreseeable risks and complications of the Procedure. The Patient understands that any medical procedure involves risks, including but not limited to:

1. Infection, bleeding, or allergic reactions to medications or materials.
2. Nerve damage, blood clots, or cardiovascular events.
3. Adverse reactions to anesthesia.
4. Unsatisfactory results or the need for additional procedures.

The Healthcare Provider has discussed specific risks related to the Patient's medical history and the specific Procedure, which include:

_____

_____

_____

V. ALTERNATIVES

The Patient acknowledges that the Healthcare Provider has explained reasonable alternative treatments or procedures, including the risks and benefits of such alternatives, as well as the risks and benefits of foregoing treatment altogether.

VI. UNFORESEEN CONDITIONS

The Patient understands that during the course of the Procedure, unforeseen conditions may arise that necessitate an extension of the Procedure or different procedures than those set forth above. The Patient hereby authorizes the Healthcare Provider to perform such other procedures as are necessary and desirable in the exercise of professional judgment, including but not limited to the treatment of emergency conditions.

VII. DISPOSAL OF TISSUE

The Patient authorizes the Healthcare Provider and/or Facility to preserve for scientific or teaching purposes, or to dispose of, any tissue, fluids, or parts that may be removed during the Procedure in accordance with standard medical practices and applicable laws.

VIII. OBSERVERS AND PHOTOGRAPHY

The Patient understands that the Facility may be a teaching institution.

Regarding observers and photography, the Patient selects the following:

Observers/Students:

☐ I CONSENT to the presence of medical students or observers during the Procedure.

☐ I DO NOT CONSENT to the presence of medical students or observers.

Photography/Video:

☐ I CONSENT to photography or video recording for medical records or educational purposes (identity will be protected).

☐ I DO NOT CONSENT to photography or video recording.

IX. NO GUARANTEE

The Patient acknowledges that the practice of medicine and surgery is not an exact science. The Patient acknowledges that no guarantees or assurances have been made to them concerning the results of the Procedure or the cure of the Patient's condition.

X. PATIENT CERTIFICATION

By signing below, I certify that:

1. I have read and fully understand this Medical Consent Form.

2. The Procedure, its risks, benefits, and alternatives have been explained to me to my satisfaction.

3. I have had the opportunity to ask questions, and all my questions have been answered.

4. I am of sound mind and capable of providing informed consent.

5. If I am signing on behalf of a minor or incapacitated person, I certify that I have the legal authority to do so.

XI. SIGNATURES

Patient Signature:

Signature: _____

Date: _____ day of _____, 20____

Print Name: _____

Legal Guardian Signature (if applicable):

Signature: _____

Date: _____ day of _____, 20____

Print Name: _____

Relationship to Patient: _____

Witness Signature:

Signature: _____

Date: _____ day of _____, 20____

Print Name: _____

Healthcare Provider Signature (Certification that consent was obtained):

Signature: _____

Date: _____ day of _____, 20____

Print Name: _____

XII. NOTARY ACKNOWLEDGMENT

State of _____

County of _____

On this _____ day of _____, 20____, before me, the undersigned Notary Public, personally appeared _____ (Name of Signer), known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that they executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal.

Signature: _____

Date: _____ day of _____, 20____

Print Name: _____

(Seal)

My Commission Expires: _____ day of _____, 20____