

**CONSENT FOR OFFICE PROCEDURE**

(Other than Routine Care)

I hereby authorize and consent to the performance of the following procedure \_\_\_\_\_

by or under direction of Dr. \_\_\_\_\_

at \_\_\_\_\_ on \_\_\_\_\_  
(Facility's name) (Date of procedure)

I further consent to the performance of any additional procedures during the course of my procedure which the physician or his designee judges necessary or desirable to correct the existing condition or any other unhealthy condition which they may discover.

I have been advised by my physician about alternatives to the procedure suggested, but I believe that the procedure suggested is the procedure I should have.

My physician has advised me fully about the nature of the procedure and the risks involved. I realize that neither the physician nor the facility can guarantee any result. Some significant and substantial risk of this particular procedure includes:

I have read this authorization and understand it.

**NOTE TO PATIENT:** YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND AGREED TO THE ABOVE, THAT THE PROCEDURE(S) HAS (HAVE) BEEN ADEQUATELY EXPLAINED TO YOU BY YOUR PHYSICIAN, THAT YOU HAVE ALL THE INFORMATION YOU DESIRE, AND THAT YOU AUTHORIZE AND CONSENT TO THE PERFORMANCE OF THE PROCEDURE(S) MENTIONED ABOVE.

DATE/TIME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

RELATIONSHIP (IF OTHER THAN PATIENT): \_\_\_\_\_

SIGNATURE OF WITNESS: \_\_\_\_\_

Signature of physician by which it is affirmed that the informed consent of the patient, or duly authorized agent, has been obtained to the outlined above.

DATE/TIME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

Time of pre-procedure Time out: _____ <input type="checkbox"/> Patient identified <input type="checkbox"/> Operative site(s) verified/marked <input type="checkbox"/> Procedure verified  _____ Patient Physician
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Patient Name  Date of Birth:
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