



FLINT

Consent for office procedure

(Other than Routine Care)

I hereby authorize and consent to the performance of the following procedure _____
_____ by or under the direction of Dr.
_____ at the Family Medicine office in Flint, MI on _____

I further consent to the performance of any additional procedures during the course of my procedure which the physician or his designee judge 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.

I have read this authorization and understand it.

NOTE to Patient: YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND AGREE 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 duty authorized agent, has been obtained to the outlined above.

Date/time: _____ Signature: _____

<p>Time of pre procedure time out: _____ Date: _____</p> <ul style="list-style-type: none"> • Patient identified • Operative site(s) verified/marked • Procedure verified • Skin prep dry time completed: ____ Yes ____ N/A <p>Patient: _____ Physician: _____</p>	<p>Patient Name: _____</p> <p>Date of Birth: _____</p>
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