

McLaren Print System Order

Order No: 90750
Order Date: 2024-12-10
Order Request Date:
User: Angie Claerhout
Phone: 9896672802

Ship Location: Bay Spine Surgery
4175 N Euclid Ave Suite 9
Bay City, Michigan 48706

Brochures
Quantity: 100
Paragon Dept No: 56087
Dept Name: McLaren Bay Spine Surgery
Company Number:

Order Total Price: 3.35

Item Number: MM-113
Item Description: Consent for Office Procedure (Other than Routine Care)
Revision Date: 11/2024
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Poster:
Misc Info:

McLaren Medical Group
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 _____ (Facility's name) on _____ (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. It was explained that during my procedure another physician, advanced practice provider or health professional student may be performing surgical tasks during the procedure, sensitive/intimate exams, or invasive procedures for educational or training purposes.

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: _____ Date: _____
- Patient identified
- Operative site(s) verified (marked)
- Physician verified
- Patient and physician verified
Patient _____ Physician _____

Spec Info: Deliver to West Side Medical Mall -Suite 9 -Bay Spine Surgery