

McLaren Print System Order

Order No: 91517 Reprint Previous Order No: 5594
Order Date: 2025-01-14
User: Melinda Adams
Phone: 989-667-6650

Ship Location: McLaren Bay Bay Physical Med & Rehab
3190 Midland Rd
Bay City, MI 48706

Forms

Quantity: 1000
Paragon Dept No: 69780
Dept Name: McLaren Bay Physical Med & Rehab
Company Number: 810

Order Total Price: 31.00

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
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)
- Procedure verified
- Skin Prep Dry Time Completed:  Yes  No
Patient Physician

Print Name: \_\_\_\_\_
Date of Birth: \_\_\_\_\_