CONSENT FOR OPERATIVE PROCEDURES & OTHER SPECIAL PROCEDURES

Patient _____ Date _____ Time _____ AM/PM

I hereby authorize _____ to perform the following procedure

_____

_____

upon _____(Name of Patient or "myself"). I do voluntarily consent to the proposed course of treatment at the Surgery Center of Volusia. It has been fully explained to me that during the course of the procedure, it is always possible that unforeseen conditions may necessitate additional or different procedures than those described to me. I authorize and request that my physician, his assistants or his designees, perform such additional procedures as are necessary. I consent to transfer to _____ Hospital in the event that my condition warrants such a transfer.

- I consent to the administration of local infiltration and/or conscious sedation and the use of narcotics, sedatives and tranquilizers as deemed advisable. I understand that with the administration of any medication there is the possibility of injury, allergic reaction, and rarely death.
- The general nature of the anticipated surgery, the medically accepted alternative procedures, and the substantial risks inherent in the proposed treatment have been explained to me. I understand such risks and I consent to the procedure. The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information.
- One or more teeth, artificial or natural, may be accidentally or unavoidably damaged in an effort to maintain a clean and unobstructed airway. Every effort will be made to prevent this, however, the Surgery Center will not be held liable for broken or damaged teeth. I understand such risks and consent to the procedure.
- For the purpose of advancing medical education, I consent to the admittance of approved observers to the Operating Room or Procedure Room. I consent to the participation, under the direct supervision of my physician of the approved resident/intern/medical student if listed here: _____
- I consent to the photographing or video taping of the procedure, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them.
- I consent to the disposal of any tissue which is removed in accordance with the medical staff rules and regulations.

_____ _____

Patient's Signature **Witness to Patient's Signature**

If patient is unable to sign or is a minor, complete the following: Reason patient cannot sign:

_____

_____ _____

Closest Relative or Legal Guardian Witness to Relative/Guardian's Signature

I have received information in language I understand and have been given an opportunity to ask questions about: (Initial)

_____ Advance Directives

_____ Notice of disclosure of ownership interest indicating my physician may be part owner at this facility

_____ I understand the Surgery Center will not compensate for any lost or misplaced personal items

_____ My rights and responsibilities as a patient

I certify that I have informed the patient of the reasonably available alternatives to the surgical and/or invasive procedures (including not having the procedure), the inherent specific potential risks and complications, benefits and alternatives of the procedure(s), and results of the procedure(s) which I consider likely to occur.

_____ _____

Signature of Physician/Practitioner **Date**