INFORMED CONSENT

I consent to the performance upon *(name of patient)* _____

the following operation/procedure _____

_____

_____

The purpose of this procedure is (*this section optional*)_____

_____

to be performed by _____, and their designated assistants.

I (we) am aware and agree to the use of photography during my procedure as a means of clinical documentation. _____

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you; it is simply an effort to better inform you so you may give or withhold your consent to the procedure.

I (we) voluntarily request the provider stated below as my physician and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition which has been explained to me.

I (we) understand that the surgical, medical and/or diagnostic procedures stated above are planned for me and I (we) voluntarily consent and authorize these procedures.

I (we) understand that my physician (provider) may discover other or different conditions that may require additional or different procedures than those planned. I (we) authorize my physician (provider), and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and / or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and / or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) realize that the risks and hazards stated above may occur in connection with this particular procedure.

I (we) understand that anesthesia involves additional risks and hazards, but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us). I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage, or even death. Other risks and hazards that may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions about the condition, alternative anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS INFORMED CONSENT. The provider has disclosed the comparative risks, benefits, and alternatives associated with performing this procedure in the ambulatory surgical facility instead of in a hospital.

_____ _____ _____

Signature of patient or authorized person | Date | Time

_____

Signature of Provider

_____

Provider name (printed)

Pend Oreille surgery center, llc.