

**OFFICE SURGICAL PROCEDURES
PATIENT INFORMED CONSENT**

On behalf of _____

Print Name of Patient

I hereby give my consent, to the treatment or procedure proposed, for myself or the patient whom I represent as follows:

1. I understand that the condition of the patient has been diagnosed as _____

In laymen's terms, that condition is known as: _____

2. I understand that the operation/ diagnostic procedure proposed by my physician is:

3. I understand that the **risks** of any operation include **infection, blood loss, nerve damage, and failure to heal**. I also understand that **no operation is guaranteed to work**, and that **any operation may fail to achieve the result desired** and may actually leave the patient in **a worse condition than the patient is at present**. I acknowledge that **no warranties of results have been made to me, and that on the contrary, no results can be guaranteed**.

4. I have discussed the **alternatives** of the procedure/ operation with my physician, including but not limited to the alternative of doing nothing further and the alternatives of attempting or continuing with any conservative treatment which may be available. Alternatives to surgery may include other measures appropriate to the patient's condition. **I DECLINE THE ALTERNATIVES.**

5. I signify by my signature on this form that:

- A. All blanks were filled in before I signed it.
- B. All questions which I had, have been answered to my satisfaction.
- C. A copy of this form has been personally given to me.
- D. I understand that the legal rights of the patient are affected by this form and that I have read it carefully or have had it read to me before signing it.

Signature of Patient or Patient Representative

Date

Signature of Witness

Time