ALLCARE MEDICAL CLINIC

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CONSENT FORM FOR PROCEDURES

PATIENT NAME: _____ DOB: _____

I hereby authorize and permit my doctor (or other health care provider) _____ AND whoever is designated as assistants to perform upon me the following procedure and accompanying anesthesia/analgesia as necessary.

_____

Name of procedure

I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment and any recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment and in the alternative forms of treatment, including non-treatment.

If any unforeseen condition arises during this procedure that in the physician's judgment calls for additional procedures, operations, or medication (including anesthesia and blood transfusion), I further request and authorize the physician to do whatever is deemed advisable.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure.

I also certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents:

_____

Date & Time **Signature of Patient or Other Responsible Person** **Relationship**

_____

Witness to Signature Only