DR. CHRISTOPHER UNGER, MD

INFORMED CONSENT AND ADVANCED DIRECTIVE FORUM SELECTION

[redacted]

I hereby permit Dr. Christopher Unger or his associate attending assistants as may be selected and supervised by him to perform the following medical treatment, or procedure (hereafter called the “procedure”):

The procedure has been explained to me and I have been told the reasons why I need the procedure. The risks of the procedure have also been explained to me. In addition, I have been told that the procedure may not have the result that I expect. I have also been told about other possible treatments for my condition and what might happen if no treatment is received.
I understand that in addition to the risks described to me about this procedure there are risks that may occur with any surgical or medical procedure. I am aware that the practice of medicine and surgery is not an exact science, and that I have not been given any guarantees about the results of this procedure.
I have had enough time to discuss my condition and treatment with my health care providers including Dr. Unger and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and I agree to have the procedure.
If something unexpected happens and I need additional or different treatment(s) from the treatment I expect, I agree to accept any treatment which is necessary.

I agree to allow Dr. Unger to keep, use or properly dispose of tissue that is removed during this procedure.

Signature of Patient or Parent/Legal Guardian of Minor Patient **Date**

[redacted]

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient’s next of kin who is assenting to the treatment for the patient, must be obtained.

Signature of Health Care Agent/Legal Guardian **Date**
(Place a copy of the authorizing document in the medical record)

Signature of Signature & Relation of Next of Kin **Date**

IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIENT, DR. UNGER MUST CERTIFY THAT THE PATIENT LACKS DECISIONAL CAPACITY.

PHYSICIAN CERTIFICATION

I have examined the above-named patient and it is my professional medical opinion that this patient lacks the decisional capacity to make informed health care decisions. I understand that if this patient has appointed a health care agent to make these decisions a copy of the patient’s Health Care Proxy must be inserted in the medical record. If the patient’s next of kin has assented to the proposed treatment for the patient, the next of kin’s relationship is indicated on the consent form.

Christopher Pelham Unger, MD **Date**

INFORMED AND EXPLAINED CONSENT

SIXTY-DAY MEDIATION/BINDING ARBITRATION OR TRIAL BY JURY

Section 1

▫ A. It is agreed by Dr. Unger and myself, that should good faith discussions not resolve a question or issue that arises from medical/surgical care, accidents, injuries, or general liability; then such claim shall be resolved exclusively by mediation AND ARBITRATION.

▫ B. Should binding arbitration fail, **I may choose to waive my right to trial by judge or jury.** Any insurance companies that insure Dr. Unger may be notified in the event that mediation/arbitration is called for. I will bear the cost of mediation or binding arbitration, and the cost of my lawyer. If mediation/arbitration is found in my favor, the largest amount that I may receive will be $4,000.00, plus whatever I have given to Dr. Unger for the procedure or service. Mediation/arbitration is understood to be concluded within sixty days from the date of service or procedure. The mediator and arbitrator may be chosen directly by me or with Dr. Unger. The choice of mediator/arbitrator will be mutually agreeable between Dr. Unger and me following the rules of the American Arbitration Association. This advance directive supersedes previous advance directives.

▫ C. Traditional legal process with judge and jury

Under Choice A and B. I understand that I may ask for all or part of $4,000.00.

Section 2

A. SPEEDY RESOLUTION: I may waive my right to mediation or an arbitration panel, or traditional litigation; and may instead, accept an option for a quick settlement, which will be understood to be compensation in full.

B. PRE-EXISTING CONDITIONS: Any claim, shall be waived and forever barred, for any condition(s) that arose prior to this medical/surgical service/administrative service accident or injury in question.

C. CHOICE: I have spoken to (consulted with) my personal representative, or lawyer, before signing this agreement, which I do freely, knowingly and voluntarily. **I understand that I may waive this form and still receive care from Dr. Unger.** All of my questions have been answered to my satisfaction. I have read this memorandum thoroughly, and have had sufficient time to think it through. I have been given a copy of this memorandum for my records.

My reason for my choice is:

_____

_____

WITNESS:

I, _____ am a facility employee who is not the patient's physician or authorized health care provider named above and I have witnessed the patient or other appropriate person voluntarily sign this form.

_____

Signature and Title of Witness

INTERPRETER/TRANSLATOR: (To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

_____

Signature of Interpreter/Translator

Signature of Patient or Parent/Legal Guardian of Minor Patient **Date**

Christopher Pelham Unger **Date**

Christopher Pelham Unger, MD
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