DAKOTA PREMIER
MEDICAL CLINIC

INFORMED CONSENT

It is very important to us that you understand and consent to the treatment your provider is providing and any procedure your provider may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered.

_____ _____

Patient's Initials or Authorized Representative Date

I, _____, Hereby authorize Kelli Gunn, DNP, FNP-C and any associates or assistants that Kelli deems appropriate, to perform _____.

The procedure has been explained to me. I understand there are risks and possible undesirable consequences associated with this procedure. If Lidocaine is used, there should be little or no pain afterwards. Further, any of these risks or complication may require further surgical intervention during or after the procedure, which I expressly authorize.

In the unlikely event that one or more of the above inherent complications may occur, my provider or covering provider will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

The reasonable alternative(s) to the procedure, as well as the risks to the alternatives, have been explained to me.

I hereby authorize Dakota Premier Medical Clinic staff the procedure authorized above.

2006 Mt Rushmore Rd Suite 2 Rapid City, SD 57701
☎ 605-416-9930 605-416-9931 dakotapremiermedical.com