Consent To Treatment and/or Procedure

Date:___________                                                Time:____________

Patient: ______________________                         S#:_________________

I hereby authorize ___________________________ of the USA Student Health Center and/or such assistants as may be selected by him/her to treat the conditions which appear indicated by the diagnostic studies already performed.

Procedure(s) to be performed__________________________________________

________________________________________________________________

The procedure(s) necessary to treat my condition has been explained to me by my provider and I understand the nature of the procedure to be performed. I have received from my provider a fair explanation of the procedure(s), including the administration of a local anesthetic if needed for my comfort, to be followed and have been told of the risks and any discomfort to be expected.

_____1. Does not resolve the problem.
_____2. Scarring
_____3. Infection
_____4. Bleeding
_____5. Other ____________________________________

It has also been explained and I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises can be made to me concerning the results of the operation, procedure and/or treatment.

It has been explained to me that during the course of the operation/procedure(s) unforeseen conditions may be revealed that necessitate the extension of the original procedure(s) or different procedure(s) than those explained to me by my provider.

I hereby certify that I fully understand the reasons why the above named surgery/procedure(s) is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment.

Signed:________________________  Date:________________

Witness:________________________  Date:________________

Revised 01/17