CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

Note to patient: there are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

_____

I authorize: Morris Ahdoot, M.D. and such physicians, associated assistants and other personnel of the hospital or medical facility chosen by him or her to perform the following:

_____

and/or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure. In common terms known as: _____

GENERAL RISKS AND COMPLICATIONS: *I am satisfied with my understanding of the more common risks and complications of the treatment or procedure anesthesia risks and death.*

SPECIFIC RISKS AND COMPLICATIONS: *I am satisfied with my understanding of the specific risks of the procedure or treatment including:*

_____

ALTERNATIVE METHODS OF TREATMENT: *I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including:*

_____

NO TREATMENT: *I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.*

SECOND OPINION: *I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.*

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT: *I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.*

OTHER SERVICES: *I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.*

PHOTOGRAPHY: *I consent to the photography, filming or videotaping of the treatment or procedure for educational or diagnostic use.*

NO GUARENTEES: *I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.*

OTHER QUESTIONS: *I am satisfied with my understanding of the nature of the procedure or treatment and all of my additional questions about the treatment or procedure have been answered.*

I have read and been given a copy of this form.

Date: _____ Time: _____ __AM __PM

Print Patient Name: _____

Signature: _____

(Patient, Parent or Legal Guardian)

Translated by (if applicable): _____Witness: _____

*Physician's Signature: __*_____