Advance Laser & Cosmetics

Consent Form

Patient Name:	Date: / /
Date of Birth:	Age:
Proposed Procedure:	
Proposed Procedure:	
Surgeon:	Anesthesiologist:

CONSENT TO OPERATION, ADMINISTRATION OF ANESTHETICS AND RENDERING OF OTHER MEDICAL SERVICES, INCLUDING CONSENT FOR RELEASE OF RECORD(S)

1. The surgery center maintains personnel and facilities to assist you in their performance of various surgical operations and other special diagnostic or therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure.
   You have the right to be informed of such risks as well as the nature of the operation or procedure; the expected benefits or effects of such operation or procedure; and the available alternative methods of treatment and their risks and benefits. Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent or to refuse any proposed operation or procedure any time prior to its performance.

2. The surgeon has recommended the operation(s) or procedure(s) set forth above. Upon your authorization and consent the operation(s) or procedure(s) set forth above, together with any different or further procedures which in the opinion of the supervising physician or surgeon may be indicated due to an emergency, will be performed on you. The operation(s) or procedures(s) will be performed by the physician or surgeon named above (or in the event of an emergency causing his or her inability to complete the procedure, a qualified substitute physician or surgeon), together with associates and assistant, including anesthesiologist, pathologists, and radiologist from the medical staff to whom the physician or surgeon may assign designated responsibilities. The person in attendance for the purpose of performing specialized medical services such as anesthesia, radiology, or pathology are not agents, servants, or employees of this surgery center and therefore are independent contractors.

3. The pathologist is hereby authorized to use his or her discretion in disposing of any member, organ, or other tissue removed from your/the patient's person during the operation(s) or procedure(s) set forth above.

4. Your signature below constitutes your acknowledgement (1) that you have read and agree to the foregoing; (2) that the operation or procedure set forth below has been adequately explained to you by the above named physician or surgeon; (3) that you authorize and consent to the performance of the operation or procedure; (4) that you authorize and consent to the administration of anesthesia for the said operative procedure; (5) that you consent that your medical record may be used for peer review; (6) the surgery center does NOT honor advance directives.

6. I have *a* responsible adult to drive me home and stay with until tomorrow morning.

Date:	Signature: *(PATIENT/PARENT/CONSERVATOR/GUARDIAN)*
Time:	If signed by other than patient, indicate relationship:
Witness:	

PHYSICIAN'S STATEMENT

I CERTIFY THAT I HAVE EXPLAINED TO THE PATIENT, TO THE EXTENT REASONABLE AND CONSISTENT WITH CURRENTLY ACCEPTABLE STANDARDS OF PRACTICE, THE NEED AND NATURE OF THE NAMED PROCEDURE(S), CONSEQUENCES AND COMMON COMPLICATIONS, HOPED FOR ACHIEVEMENT AND OUTCOME, PLUS ANY PERTINENT ALTERNATIVES TO THE PROCEDURE(S).

Physician Signature	Date