

ORTHOPAEDIC BONE & JOINT SPECIALISTS, P.A.
CONSENT TO SPECIFIC PROCEDURE OR TREATMENT

I, _____ AGE _____ ACCOUNT # _____
Name of Patient

AGREE TO THE PROPOSED PROCEDURE(S) OR TREATMENT(S):

I acknowledge that my doctor has determined the procedure(s) and/or treatment(s) listed above may be beneficial in the diagnosis or treatment of my condition.

The nature and purpose of the procedure(s) and/or treatment(s) listed above, alternative method(s) of treatment, the material risks involved, and the possibility of complications have been fully and to my satisfaction explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

It has been explained to me, and I fully appreciate, that the procedure(s) and treatment(s) contemplated, and further procedure(s) or treatment(s) which may become necessary or advisable to adequately and properly treat me, all involve risks of complications, serious injury, or even death, from known and unknown causes. I affix my signature to this consent, with knowledge that such risks exist.

I hereby authorize and direct _____ and associates or assistants of their choice to perform the procedure(s) or treatment(s) listed above including whatever incidental procedure(s) and/or additional services involving anesthesia, radiology, pathology, administration of medications and the like, as may be necessary or advisable, including such other and further procedure(s) or treatment(s) which may not be presently contemplated, but which my physician(s) may discover, in the course of performing the presently contemplated procedure(s) or treatment(s) are necessary or advisable in the exercise of sound medical judgment, to adequately and properly treat me.

I understand that anesthesia has potential risks including, but not limited to: respiratory and circulation problems, drug reactions, infections, headaches, nerve damage, heart attacks, strokes, or even death. I am aware that during the procedure(s) an increase in anesthesia may become necessary without advance explanation to me. I have had anesthesia explained to me, along with alternatives, and I believe that I have sufficient information to give this informed consent.

I understand that Orthopaedic Bone & Joint Specialists may retain, preserve or dispose of any specimens, tissues, or parts of organs taken from my body during my procedure(s) or treatment(s) performed upon me in keeping with customary practices of Orthopaedic Bone & Joint Specialists.

I CERTIFY: This form has been explained to me. I have read the contents of this form or the contents have been read to me. I understand its contents and the explanation of the contents was made and all blanks or statements requiring insertion or completion were filled in and all items not applicable were stricken before I signed.

**Witness
authorized to**

**Signature of Patient or Person
sign for patient**

Time _____
Witness

Date _____

Patient cannot request or authorize because

**ORTHOPAEDIC BONE & JOINT SPECIALISTS, P.A.
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Relationship

to

patient
