



Consent to operation or other medical services

Patient: _____ Date: _____ Time: _____ a.m. p.m.

- 1.** I authorize performance upon _____ of the following operation(s) and/or procedure(s): _____

_____ to be performed by Dr. _____ and/or associates or assistants of his/her choice, which may include medical or surgical residents and/or fellows. I understand a representative from a medical company, such as a sales representative, may be present during the surgical procedure to provide verbal technical advice to the surgeon, anesthesiologist and/or operating room staff.

- 2.** During the course of the operation(s)/procedure(s), unforeseen conditions may arise that may necessitate additional surgery or other therapeutic procedures to promote my well-being. I consent to other surgery/procedures as may be considered necessary or advisable by my physician(s) under the circumstances.
- 3.** I consent to the use of sedation/anesthetics, as may be necessary and advisable, except _____. I understand that sedation/anesthesia may involve serious risk even though administered in a careful manner. I further understand that a patient should not drive, operate equipment, or drink alcoholic beverages for at least 24 hours after sedation/anesthesia.
- 4.** To further medical and scientific learning, I consent to the photographing and/or videotaping of the operation(s)/procedure(s) that may reveal portions of my body, with the understanding that my identity is not to be revealed. To advance medical education, I give my permission for physicians, nurses, medical students, interns, residents and other advanced medical education individuals who are participating in an educational process approved by Cigna to be present during the operation(s)/procedure(s).
- 5.** I consent to the examination for anatomical purposes and disposal by the surgery center of any tissue or body parts that may be removed during the operation(s)/procedure(s).
- 6.** I understand that some physician(s) performing the operation(s)/procedure(s), administering sedation/anesthesia and those physicians providing services involving pathology and radiology may not be agents, servants or employees of the surgery center nor of one another, but may be independent contractors.

7. I have been advised that prosthetic devices including, but not limited to, dentures, bridges, caps, crowns, fillings, dental implants, etc. are more easily damaged than normal teeth. I have been advised to remove all removable prosthetic devices prior to surgery, and I agree that responsibility for loss or damage will be mine if I fail to remove such dental or other prosthetic devices.

8. My physician has explained to me the nature, purpose and possible consequences of the operation(s)/ procedure(s) as well as significant risks involved, possible complications, expected postoperative functional level, expected alterations in lifestyle/health status and alternative methods of treatment. I further understand that the explanation I have received is not exhaustive and that there may be other, more remote, risks and consequences. I have been advised that a more detailed explanation will be given to me if I so desire. I have received no guarantee or warranty concerning the results/outcome and cure and have been given an opportunity to ask and have my questions answered to my satisfaction.

9. In the event a device is implanted during the operation(s)/procedure(s) and federal law requires the tracking of that device, I consent to release my social security number to the manufacturer of the device.

10. I confirm that I realize that a scar or scars may arise as a result of any surgical procedure.

11. I acknowledge that all blank spaces to this consent have been either completed or crossed off prior to my signing.

12. The patient is unable to sign for the following reason:
 - The patient is a minor.
 - The patient lacks the ability to make or communicate medical treatment decisions because of:

Patient or Legally Authorized Representative	Date	Time
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Relationship to Patient

Witness	Date	Time
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