Informed Consent for Treatment at Piedmont HealthCare, P.A.

Patient Name: (PRINT): ___________________________________ Medical Record Number: ________________________

Practice: ____ Date: ____

You have asked Piedmont HealthCare to provide you with healthcare services, including all diagnostic tests, examinations and surgical or medical treatments as may be deemed necessary by your physician. By signing this form you agree that Piedmont HealthCare and your physician or his/her designee have explained to you the risks, probable benefits and alternatives to the proposed treatment or procedure, and that you have had an opportunity to ask questions and receive information necessary for you to make an informed decision about your healthcare.

1. I, _____________________________________ herby authorize Dr. _____________________________ and his/her associates and such assistants as may be selected or designated by them, to provide the following treatment or perform the following procedure: {*name of treatment or procedure*}

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2. The nature and purpose of the treatment or procedure to be performed, the risks involved, as well as possible alternatives and possible complications have been explained to me. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction.

3. I understand that during the course of any treatment or procedure unforeseen conditions may become apparent which may require changes or additions to, or abandonment of, the originally planned treatment or procedure. I authorize my physician and his/her associates or assistants to provide such additional or different treatment or perform such additional or different procedures as they deem necessary or advisable in the exercise of their professional judgment.

4. I am aware that the practice of medicine and surgery is not an exact science, and that all treatments and procedures carry some inherent risk. I agree that no guarantees have been made to me about the likely results of the proposed treatment or procedure.

5. I have also been informed that some risks, such as blood loss, infection, allergic reactions to drugs or anesthesia, injury to other organs, blood clots in veins or lungs, cardiac arrest and even death, are all possible complications in the performance of an operative procedure. Specific risks and known complications associated with the planned operative procedure have been explained to me, and include:

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6. I agree to the use of regional anesthesia, conscious sedation and/or general anesthesia depending upon the judgment of the anesthesia care team. I understand that certain anesthetic risks, which could cause serious bodily injury or even death, are inherent in any procedure involving anesthesia.

   This form has been fully explained to me; I have read it or had it read to me, and I understand its contents.

Signature: ____

Patient or person authorized to consent for patient

____

Relationship to patient (patient; parent; legal guardian; etc.)

Witness: ____

Date: ____

Physician
Signature: ____