Consent to Operation, Anesthetic and Other Medical Services

Date/Time: ______________________

1. I authorize the performance upon _____________________________________ of the following
   Operation/ procedure _____________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

   (State nature and extent of operation/procedure to be performed)

   under the direction of Dr. _________________________________________ and/ or such assistants as may be selected
   by him/her to perform such operation/procedure.

2. I recognize that during the course of the operation, additional different approaches or services than the procedure listed above
   maybe necessary. I authorize and request that the above named surgeons and/or associates, partners, assistants or designees
   perform such procedures if in his/her professional judgment it is necessary and in my best interest.

3. I understand the above named procedure(s) may require that I undergo some form of anesthesia; I consent to the
   administration of such anesthetics as may be considered necessary or advisable by the responsible anesthesia provider
   participating in my care.

4. I consent to the photographing or videotaping or other observation of the operation or procedures to be performed;
   including appropriate portions of my body, for medical scientific or educational purposes.

5. I also understand that medical, nursing and allied health students/trainees maybe present during the procedure and they observe
   or assist in my care, under the direction of my surgeon and other hospital staff members.

6. I consent to the presence of sales/clinical representatives during the procedure. I understand that sales/clinical representatives do
   not participate in the procedure.

7. I consent to the appropriate disposal (by hospital authority) of any tissue or members which may be removed during the course of
   the surgical procedure.

8. My physician, Dr. ____________________________________________, has explained to me the nature, purpose
   and possible consequences of the operative procedure that is being performed. He/she has also discussed possible alternative
   methods of treatment, the risks involved with this procedure and the possibility of complications that may occur. No one has
   made or given me a guarantee or assurance regarding the results of the operative procedure.

9. I, THE UNDERSIGNED, HAVE HAD THIS FORM EXPLAINED TO ME AND FULLY UNDERSTAND THE CONTENTS
   OF THE AUTHORIZATION.

   SIGNED ____________________________
   (Patient or Authorization Person)

   ____________________________
   (Relationship to Patient)

   WITNESS ____________________________
   (Witness to signature or phone consent)

   WITNESS ____________________________
   (Witness to signature or phone consent)

   I HAVE EXPLAINED THE RISK, BENEFITS, POTENTIAL COMPLICATIONS, AND ALTERNATIVES OF THE TREATMENT
   TO THE PATIENT OR LEGAL REPRESENTATIVE AND HAVE ANSWERED ALL QUESTIONS TO THE PATIENT’S
   SATIFICATION, AND HE/ SHE HAS GRANTED CONSENT TO PROCEED.

   ____________________________
   Date/ Time ____________________________

   Physician Signature