CONSENT FORM

______________________________	______________________________	______________________________
Patient Name	Account Record	Date

____ ______________________________

Proposed Procedure — Surgeon

______________________________	______________________________	______________________________
Date of Birth	Age	Sex

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

1. The surgery center and clinic maintain personnel and facilities to assist you/the patient's physicians and surgeons 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 fight to consent to or refuse any proposed operation or procedure any time prior to its performances.

2. Your/the patient's physician and surgeons have recommended the Operations or procedures 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 patient. The operations or procedures 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 anesthesiologists, 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 no agents, servants, or employees of the center or you/the patient's physician or surgeon, but are independent contractors, and therefore, your agents, servants or employees.

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 operations(s) or procedures (s) set forth above.

4. Your signature below constitutes that 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.

____	______________________________
Signature	Date

______________________________	______________________________
Time	Relationship to Patient (if signed by other than patient)

____

Witness

PHYSICIAN'S STATEMENT

I certify that I have explained to the patient, to the extent reasonable and cinsistant with currently acceptable standards of practice, the need and nature of the named procedure(s), condequesnces and common complications, hoped for achievement and outcome, plus any pertinent alternatives to the procedure(s).

____	______________________________
Signature	Date