Natomas Family Practice

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Consent to Medical/Surgical Office Procedure

I (or my authorized representative, i.e., parent guardian), ________________________, consent to the medical/surgical procedures outlined below to be performed by __________________________.

The proposed medical/surgical procedure is ________________________for the diagnosis/treatment of ________________________________. The procedure has been explained to me in terms that I understand. The explanation included:

- The nature and extent of the procedure to be performed.
- General risks which may include pain, scarring, bleeding, infection or death.
- The benefits of the procedure.
- The estimated period of incapacity or convalescence, if any.
- The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all.

I was given the opportunity to ask any questions I have regarding the procedure and I have had those questions answered to my satisfaction.
Patient/Guardian/POA Initials: _______

I understand that I may consult or could have consulted with another physician about this procedure. **Patient/Guardian/POA Initials:_______**

I understand that I have the right to refuse any medical/surgical treatment recommended at any time prior to its performance.
Patient/Guardian/POA Initials: _______

I authorize my physician to perform such additional procedures which in his/her judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment. **Patient/Guardian/POA Initials: _______**

If any unforeseen condition arises during this procedure which requires transportation to a hospital, additional procedures, operation or medication including anesthesia and blood transfusions, I further request and authorize my physician to do whatever he/she deems advisable on my behalf. **Patient/Guardian/POA Initials: _______**

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure. Patient/Guardian/POA Initials: _______

I acknowledge that I have read (or had read to me) and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize my physician to perform the above discussed procedure.
Patient/Guardian/POA Initials: _______

I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive **today _____________.**
Patient/Guardian/POA Initials: _______

I understand it is my responsibility to provide accurate and current Insurance information for primary and secondary if applicable. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement. **Patient/Guardian/POA Initials: _______**

___________________________________   ____________________

Patient's Signature/Power of Attorney/Guardian   Date of Birth

I verify that I have explained the information contained in this document to the patient or person giving consent. It is my opinion that the person granting consent has fully understood all subjects discussed.

____

Witness to Signature

___________________________________   ___________________________________

Date / Time   Physician Signature