RADIANCE SURGERY CENTER
CONSENT FOR SURGERY

1. I, _____ authorize Dr. _____as my physician, and his/her assistants and appropriate center personnel as my physician deems necessary, to perform the following medical/surgical procedure(s), which I understand to be:
   _____
   _____
2. I consent to the administration of anesthesia and to the selection of the appropriate kind and method as determined by the anesthesia provider.

3. I acknowledge that the nature and purpose of the operation, alternative methods of treatment, risks involved, and my physician to my satisfaction has explained possible consequences and possible complications to me.

4. I acknowledge that my physician explained to me the comparative risks, benefits, and alternatives associated with performing my surgical procedure in a surgery center instead of in a hospital setting.

5. It has been explained to me by my physician and I understand that during the course of the operation unforeseen conditions may appear which require an extension of the original procedure from that described above and I authorize and give my consent for such surgical procedures as any physician should find necessary or desirable in the exercise of professional judgment.

6. I acknowledge that the risks and possible consequences associated with the expected treatment, procedures and any surgery have been explained to me, including, but not limited to, blood loss, brain and nerve damage, infection, cardiac arrest, and death which are risks inherent in the performance of any procedure. 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 about the results of any treatment, procedure and/or surgery.

7. I hereby give permission for the tissue that is sent to the laboratory to be properly disposed of by the pathologist or be used for scientific purposes.

8. I consent to the photographing or video recording of the operation or procedure performed for medical, scientific, or educational purposes.

9. I am aware that my surgeon may have an ownership interest in the Radiance Surgery Center. I am free to choose to go to another healthcare facility for this procedure and, if I do, it will have no effect on my relationship with my physician.

10. I certify that I have read this consent form or had it read to me and fully understand its contents and have had all my questions answered to my satisfaction.

11. I consent to observers/medical professionals, deemed necessary by my physician, to be present during my procedure.

_____ _____ _____A.M./P.M.
Patient/Guardian Signature Date Time

_____ _____
Relationship to Patient Witness

I have explained to the above individual of the nature, purpose and risks/consequences of the above-described surgery/procedure, alternative method of treatment and the consequences if no treatment is taken.
Physician's Signature:_____Date:_____ Time:_____A.M./P.M.