BISMARCK
SURGICAL ASSOCIATES
Consent for Surgery and Special Procedures

Patient Name | Sex
Acct # | DOB | Age
Case | Surgeon | DOS

1. Doctor _____ has explained to me:

a. My current medical condition,
b. The proposed procedure,
c. Alternative treatments for my medical condition,
d. The possible and probable risks involved with the treatment,
e. The possible and probable risks involved without treatment,
f. The foreseeable recovery process, and the long-term effects associated with treatment of my condition

2. I request Doctor _____ to perform:

3. I realize that during the course of the medical procedure, circumstances may arise or conditions may be discovered which necessitate an extension of the planned procedure or the performance of a different procedure. I authorize the performance of other procedures as my surgeon, in exercise of their judgment decides is necessary, I understand my surgeon will be present for key or critical elements of my operation. I authorize my surgeon or anesthesia care provider to transfer me to a hospital as he/she deems necessary.

4. No guarantees have been made to me regarding the results of the procedure.

5. I further agree to the following:

Specimens: will be examined, reviewed and disposed of by the contracted laboratory or the surgery center. Any other use of specimens removed from my body will be authorized by my formal consent.

Observers: may be present, including but not limited to: employees of the surgery center, equipment representatives, medical students, residents, fellows or physicians approved by my attending surgeon.

Pictures/video: may be taken and stored in the medical record and/or the physician clinic. The pictures maybe used in any manner consistent with HIPAA guidelines.

Valuables: you were instructed to leave all valuables, jewelry, and piercings at home. Bismarck Surgical is not responsible for any lost or stolen items. Bismarck Surgical is not responsible for any injury caused by jewelry or piercings known or unknown.

6. I have had sufficient opportunity to discuss my condition and the procedure to be performed with my physician, and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed treatment.

7. If a health care provider has a significant exposure to my blood or body fluids, I consent to have my blood drawn and tested for HIV and other blood diseases. This consent shall be effective, even if I am then under anesthesia or other mind-altering medication. I understand that the test results maybe disclosed as authorized by law.

8. I received the notice of patient rights both verbally and written prior to the date of this procedure. I am aware of my right to have an Advance Directive. I am aware of physician ownership in this facility.

_____ Date & Time _____
Signature of Patient / Significant other

_____ Date & Time _____
Signature of Witness

_____ Date & Time _____
Signature of Witness for telephone consent only