SOUND SURGEONS
SURGERY CENTER

FORM SC10.4.2a

Sound Surgeons Surgery Center

Patient Name: _____

Washington State law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision-making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1. I hereby authorize Dr. _____ and/or such associates or assistants as may be selected by said physician to treat the following condition(s) which has (have) been explained to me:

_____
_____
_____
_____

2. The procedures planned for treatment of my condition(s) have been explained to me by my physician. I understand them to be:

_____
_____
_____
_____

I understand this procedure will be performed at Sound Surgeons Surgery Center.

3. The potential benefits of this procedure include the possible diagnosis or treatment of my condition listed above. While this procedure is often an effective treatment, not all conditions, diseases, or problems can be diagnosed or treated with this treatment or procedure.

4. I understand that there are potential risks, complications, and side effects associated with any medical or surgical procedure. Although it is impossible to list every potential risk, complication and side effect, I have been informed of some of the possible risks, complications, and side effects of this procedure. These: could include, but may not be limited to, the following: severe loss of blood; infections; nausea and vomiting; blood clots in legs; blood clots in the lungs; and cardiac arrest. Some of the risks, complications, and side effects are not serious or do not happen frequently.
Some risks, complications, and side effects that occur only very rarely cannot be predicted or prevented by the physician performing the procedure or the anesthesiologist performing anesthesia.

Although most procedures have good results, I understand that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications, and side effects. These potential risks and complications could result in the need to repeat the procedure; additional medical or surgical treatment or procedures; hospitalization; blood transfusions; or very rarely, permanent disability or death.

5. I have chosen to undergo this procedure after considering alternative forms of diagnosis and/or treatment for my condition, including non-treatment, or other procedures or tests. Each of these alternative forms of diagnosis or treatment has its own potential benefits, risks and complications.

6. I consent to the administration of anesthesia by my attending physician, by an anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risk of complications and serious possible damage to vital organs such as the brain, heart, lung, liver and kidney and that in some cases may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes.

7. I consent to the transfusion of blood and blood products as deemed necessary.

8. I certify that I have read or had read to me the contents of this form. I have read or had read me and will follow any patient instructions related to this procedure.
I understand the potential risks, complications, and side effects involved with the proposed treatment or procedure and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects, and alternatives to this treatment or procedure.
I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician.

I CONSENT TO THE ABOVE PROCEDURE(S) AND TO ADDITIONAL PROCEDURES AS DEEMED NECESSARY OR APPROPRATE BY MY PHYSICIAN.

_____	_____	_____
Patient's Signature	Printed Name	Date and Time

_____	_____
Witness to Signature	Date and Time

I ATTEST THAT I EXPLAINED THE ABOVE PROCEDURE(S) TO THE PATIENT OR AUTHORIZED CONSENTER.

_____	_____	_____
Signature of Physician	Printed Name	Date and Time