DUCHARME
General Surgery PLLC

CONSENT TO OPERATIONS OR OTHER PROCEDURE,
ANESTHETICS AND OTHER MEDICAL SERVICES

I, _____ DOB:_____ DATE:_____TIME:_____
Patient/legal representative

I authorize Dr. Sarah E. Ducharme, to perform the following operation or procedure(s):

_____

(state nature and extent of each operation or other procedure)

I consent to the administration of such anesthesia as may be considered necessary or advisable with the exception of:_____
(if none, write none)

I confirm the following: That my physician has explained to me the nature, purpose and possible consequences of ach operation or procedure as well as the risks involved, possible complications and possible alternative methods of treatment: that I understand that the explanation I have received is not exhaustive and that other, more remote risks, and consequences may arise; that I have been advised that a more detailed and complete explanation of any of the foregoing matters will be given to me if I so desire; That I do not desire such further explanation; and that I acknowledge that I have received no guarantees or assurances from anyone as to the result that may be obtained.

I consent to the disposal my medical personnel of any tissue or body parts that may be removed

I understand that my operation may require an assistant. This surgical assistant could be one of the following, but not limited to: MD (Medical Doctor), PAC (Physician Assistant), RNFA (Registered Nurse First Assistant), NP (Nurse Practitioner)

YOU MAY RECEIVE BILLINGS FROM OTHER PROVIDERS FOR THEIR ASSISTANCE WITH YOUR SURGERY (i.e. Anesthesia, Pathology, Laboratory, Surgical assistant, X-ray) NOT AFFILIATED WITH DUCHARME GENERAL SURGERY PLLC

I acknowledge that all blank spaces to this document have either been completed or crossed off prior to my signing.

_____ _____
Witness Date. Patient or legal representative. Date

DO NOT SIGN THIS CNSENT IF THERE ARE ANY QUESTIONS OR WORRIES THAT YOU HAVE <u>NOT</u> DISCUSSED WITH YOUR DOCTOR

Doctor's statement: I attest that I had an informed consent discussion with my patient or their legal representative regarding the planned treatment or procedure. I have explained the patient's condition, need for treatment, the procedure, related risks, relevant treatment options and their risks. I am of the opinion that the patient/legal representative understands the information provided and that I have answered all of the patient's questions.

_____. _____. _____
Doctor's Signature Date Time (am/pm)