California 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 s 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. The procedures planned for treatment of my condition(s) has (have) been explained to my by my physician, Dr. _____. I understand them to be: (write the **procedures planned**)

   _____

   _____

   _____

2. I recognize that, during the course of the operation, postoperative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those above set forth. **I therefore authorize my above named physician, and his or her assistants or designees, to perform such surgical or other procedures as are in the exercise of his, her or their professional judgment necessary and desirable.** The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time of surgery.
3. **I have been informed that there are significant risks** such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. **I acknowledge that no warranty or guarantee has been made to me as to result or cure.**
4. I understand that my physician and/or anesthesiologist may order my transfer to an acute care hospital due to a health condition or complication which requires hospitalization.
5. Any tissues or parts surgically removed will be disposed of at the discretion of the physician or pathologist in accordance with accustomed practice.
6. I consent to the photographing or video taping of the treatment or procedure for diagnostic, documentation or educational use. I also understand that my medical record may be used in the quality improvement practices of the center, always maintaining my privacy and anonymity.
7. I will remove, and take responsibility for, all prosthetic devices such as glasses, contact lenses, hearing aids, and dental prosthesis if so directed. I shall not hold the Center liable for loss or damage to any money or article of value unless that item has been placed in safe keeping by the Center.
8. I have a responsible adult arranged to drive me home and stay with me.
9. I consent to the administration of anesthesia as recommended by my surgeon and anesthesiologist.
10. **FULL DISCLOSURE**: I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment and the recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment, and in the alternative forms of treatment, including non-treatment.

**I certify that this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand it's contents.**

Date_____ Time_____ AM PM

_____
**PHYSICIAN'S SIGNATURE**

_____
Patient / Other Legally Responsible Person's Signature

_____
Relationship of Legally Responsible Person to Patient

_____
Witness' Signature

## PACIFIC ENDO-SURGICAL CENTER

AUTHORIZATION FOR SURGERY