SUMMIT

I, _____ authorize Dr. _____or his/her associates and such residents/assistants, as may be selected by him/her to perform upon me (or the above named patient) the following procedure(s)/treatment(s):

_____

_____

I understand that during the course of the procedure/treatment, unforeseen circumstances may develop which may require an extension or modification of the original procedure/treatment or a different procedure/treatment from that described above. I hereby authorize my physician, his/her associates, or resident(s)/assistants(s) to perform such procedure/treatment as they may deem necessary and advisable. This authority shall extend to the performance of procedure/treatment for conditions, which are not known to my physician at the time the original procedure/treatment is commenced.

My physician has adequately explained to me the material risks and likely complications that are or may be associated with this procedure/treatment, the benefits, the alternatives, if any, and the probable results if the conditions remain untreated. I have had the opportunity to fully discuss these matters with my physician and have had the opportunity to ask any questions I might have. 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 this procedure/treatment.

I consent to the administration of such anesthetics/conscious sedation as are necessary. Further, if during the course of procedure/treatment, it is determined by the physician that additional anesthetic is necessary, or advisable, I consent to that as well.

Should a bloodborne exposure occur during the procedure, I consent to the drawing of blood for HIV testing. The results of this test will be placed in my medical record and protected in accordance with applicable laws.

I authorize Summit Surgical Center to dispose of any severed tissue, surgical hardware, organs or parts in accordance with their policy.

A vendor representative may be present during the procedure/treatment. The role of the vendor representative is to serve as a resource to the physician and/or nurses regarding equipment.

I authorize my physician to photograph and/or videotape my procedure/treatment of purposes of medical documentation and/or medical education. These pictures (without any other identification such as name) may be used for resident training, published in journals or used for any other purpose that is deemed to be in the interests of my medical care or medical education, or knowledge in general. I understand that I will receive no compensation from Summit Surgical Center or my physician. I understand that I may refuse to allow such photographing/videotaping without any consequence.

I certify that I have read and fully understand this consent form which has been preceded by an explanation from my physician(s). I acknowledge and am satisfied that I have been adequately informed concerning material risks and likely complications, the benefits and alternatives, if any, of this procedure/treatment including the likely outcome if this procedure/treatment is not done and specifically consent to such.

_____	_____	_____
Patient/Relative/Representative and Relationship Signature	**Date**	**Time**
_____	_____	_____
Validation of Signature	**Date**	**Time**

Attestation Statement: The above referenced patient has been provided with an explanation of the material risks and likely complications that are or may be associated with this procedure/treatment, benefits, alternative if any, including the likely outcome of not having the procedure/treatment.

_____	_____	_____
Physician Signature	**Date**	**Time**

SUMMIT
SURGICAL CENTER, LLC

CONSENT TO PROCEDURE/TREATMENT