Consent to Operation, Anesthesia, Special Treatment or Procedures

Date: __/__/____ Hour: __; __ AM PM

1. I hereby authorize **John Viscovich, DPM** to perform the following operation/procedure upon me:
   _____
   _____
2. **Dr. John Viscovich** has fully explained to me the nature and purpose of the procedure. The complications that may occur during and following the operation, as well as the possible alternatives to the proposed operations.
3. 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 concerning the results of the above operation, treatments, or procedures. I understand that the explanation that I have received is no exhaustive and that other, more remote risks and consequences may arise I have been advised that if I desire more detailed and complete explanation of any of the foregoing, such explanation will be given to me.
4. I further consent to the administration of such anesthetics as may be considered necessary. I recognize that there are always risks to life and health associated with anesthesia and such risks have been explained to me.
5. I further consent to the examination and disposal by hospital/medical authorities, in accordance with its accustomed practice of any tissue or parts which may be removed.
6. It has been explained to me that during the course of any operation unforeseen conditions may be revealed that I, therefore, authorize and request that the above named physician perform such surgical or other procedures including, without limitation, the administration of blood or blood derivatives, as are necessary desirable in the exercise of professions of judgement. The authority granted under this paragraph shall extend to treating all conditions that require treatment and are not known to the above physician at the time the operation is commenced.
7. I certify that I have read and fully understand that above consent, that the explanation therein referred to were made and that all blanks or statements requiring insertion or completion were filled in and any inapplicable paragraphs stricken before I signed.
8. I also certify that I was given the opportunity to question any concerned with any specific portion of my care and treatment.

_____ or _____

Patient's Signature **Signature of Person Authorized to Consent**

_____ _____ _____

Print Patient's Name **Date** **Relationship**

_____

Witness

PHYSCIAN'S CERTIFICATION

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed treatment, I have also offered to answer any questions and have fully answered all such questions. I believe that the patient fully understands what I have explained and answered.

Physician's Signature: _____ Date: __/__/____