McLaren Business Products

McLaren Print System Order

Order No: 8071
Order Date: 2015-01-08
User: Melissa Hayes
Phone: 989-779-5624

Ship Location: Pickard Clinic
4639 E. Pickard St., Suite A
Mt. Pleasant, MI 48858
Forms
Quantity: 100
Paragon Dept No: 81075050566420
Dept Name: Pickard Clinic
Company Number: 810

Order Total Price: 0.00

Item Number: MM-113
Item Description: Consent for Office Procedure (Other than Routine Care)
Revision Date: 8/2013
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Ambulatory Care Center, McLaren Occupational Health/Convenient Care Center

CONSENT FOR OFFICE PROCEDURE
(Other than Routine Care)

I hereby authorize and consent to the performance of the following procedure _____

_____

_____

by or under direction of Dr. _____

at _____ on _____
(Facility's name) (Date of procedure)

I further consent to the performance of any additional procedures during the course of my procedure which the physician or his designee judges necessary or desirable to correct the existing condition or any other unhealthy condition which they may discover.

I have been advised by my physician about alternatives to the procedure suggested, but I believe that the procedure suggested is the procedure I should have.

My physician has advised me fully about the nature of the procedure and the risks involved. I realize that neither the physician nor the facility can guarantee any result.

I have read this authorization and understand it.

NOTE TO PATIENT: YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND AGREED TO THE ABOVE, THAT THE PROCEDURE(S) HAS (HAVE) BEEN ADEQUATELY EXPLAINED TO YOU BY YOUR PHYSICIAN, THAT YOU HAVE ALL THE INFORMATION YOU DESIRE, AND THAT YOU AUTHORIZE AND CONSENT TO THE PERFORMANCE OF THE PROCEDURE(S) MENTIONED ABOVE.

DATE/TIME: _____ SIGNATURE _____

RELATIONSHIP (IF OTHER THAN PATIENT): _____

SIGNATURE OF WITNESS: _____

Signature of physician by which it is affirmed that the informed consent of the patient, or duly authorized agent, has been obtained to the outlined above.

DATE/TIME: _____ SIGNATURE _____

Time of pre-procedure Time out: _____
____Patient identified
____Operative site(s) verified/marked
____ Procedure verified

_____
Patient Signature Date/Time

_____
Physician Signature Date/Time

CONSENT FOR OFFICE PROCEDURE

Patient Name

Date of Birth