Consent to Medical Office Procedure

I, (or my authorized representative, i.e., parent, guardian), _____,

give my permission to _____, and such designees as needed to perform

_____.

The proposed medical procedure is for the diagnosis/treatment of_____

_____

The proposed medical procedure has been explained to me in terms that I understand. The explanation included:

- The nature, description and extent of the procedure or treatment to be performed,
- The most frequently occurring risks of the procedure or treatment involved,
- General risks which may include, but not limited to, pain, scarring bleeding and infection,
- The benefits of the procedure,
- The estimated period of incapacity or convalescence, if any, with expected recovery signs and symptoms,
- The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all with potential results, outcomes and expectations.

I understand that I may consult or could have consulted with another provider about this procedure.

I understand that the use of PRP, amniotic fluid, cord blood products, and HUCT-MSC stem cells are not FDA approved and are considered experimental treatment at this time.

I understand that I have the right to refuse any medical treatment recommended at any time prior to its performance.

I authorize my provider to perform such additional procedures which in his/her judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.

If any unforeseen condition arises during this procedure I further request and authorize my provider to do whatever he/she deems advisable on my behalf.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure or my condition would be cured or improved.

I authorize the provider performing the procedure, or his/her staff, associate, or assistant to whom the physician may assign the responsibility, to use his or her discretion in disposing of or using any tissue or fluids that may be removed during the procedure for disposal, examination and laboratory (pathology) testing.

I authorize that a provider in training may participate in my care; a representative or technician from a medical device company may be present at the procedure; medical photography may be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in the photo or text.

I acknowledge that I have read (or had read to me) and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize my provider to perform the above discussed procedure.

_____

Patient's Name and Signature/Power of Attorney/Guardian/Parent/Representative

Date:_____ **Time:** _____

_____ _____

Relationship to the patient if Representative signed the consent **Witness (Optional)**

I verify that I have explained the information contained in this document to the patient or person giving consent. It is my opinion that the person granting consent has fully understood all subjects discussed.

Provider Signature_____ **Date:**
_____ **Time:** _____