Informed Consent

Patient Name: _____

DOB: _____

Today's Date: _____

1. I authorize Doctor _____ and other assistants or health care providers as he or she decides are necessary, to perform the following procedures(s)/treatment(s). **[Circle]**

   Hemorrhoid Banding Other: _____

2. I realize that during the procedure, something may be found or happen that may lengthen the time of care or an additional procedure or therapy may be needed. Therefore, I authorize the other procedures as the physician, in his or her professional judgment, decides are needed.

3. The risks and benefits of this procedure/treatment have been explained to me in terms I understand. I have been informed of the possibility of complications resulting from the procedure/treatment. I have had an opportunity to ask my physician any questions I have concerning the procedure/treatment. The physician has answered my questions before being given pain medication.

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4. In the event the physician or staff is exposed to my blood, body fluids or contaminated material, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory will perform all required tests at no cost to me. I understand I will be told if this occurs and I will be given the results of my blood tests.

5. I understand 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 the procedure(s)/treatments(s).

6. I understand that any healthcare encounter, including this procedure, may present a risk of COVID-19 transmission.

Signature of Patient/Legal Guardian:

_____

Date/Time: _____

Witness Signature:

_____

Date/Time: _____

If patient is unable to sign permit, state reason:

_____