CONSENT TO PROCEDURE AND MEDICAL SERVICE

COMPLETE ORIGINAL IN INK FOR FACILITY CHART
PATIENT MUST BE AWAKE, ALERT AND ORIENTED WHEN SIGNING

DATE:_____ TIME:_____ AM__ PM__

I AUTHORIZE THE PERFORMANCE UPON _____
PATIENT'S NAME

OF THE FOLLOWING PROCEDURE. **AUTOLOGOUS PLATELET RICH PLASMA & OR BONE MARROW ASPIRATE INJECTION**

TO BE PERFORMED UNDER THE DIRECTION OF DR._____

1. I HAVE BEEN ADVISED THAT THERE IS A FAVORABLE LIKELIHOOD OF SUCCESS, BUT I UNDERSTAND THAT A COMPLETELY SUCCESSFUL OUTCOME MAY NOT BE ACHIEVABLE, AND THERE ARE NO GUARANTEES REGARDING THE OUTCOME. I ALSO UNDERSTAND THAT CERTAIN ADVERSE EVENTS COULD OCCUR AS A RESULT OF THE PERFORMANCE OF THE PROCEDURE OR TREATMENT, INCLUDING ALLERGIC REACTION, PAIN, HYPOTENTION AND POSSIBLE CONSEQUENCES THEREOF. I UNDERSTAND THAT CARE BY HEALTH PROFESSIONAL MAY BE NEEDED FOLLOWING THE PROCEDURE OR TREATMENT, RELATED TO FULL RECOVERY. I UNDERSTAND THE ALTERNATIVES TO THIS PROCEDURE INCLUDING MY RIGHT O REFUSE TO CONSENT TO IT AND I NEVERTHELESS HAVE DECIDED TO CONSENT TO PERFORMANCE OF THE PROCEDURE OR TREATMENT.
2. I CONSENT TO THE PERFORMANCE OF PROCEDURES IN ADDITION TO OR DIFFERENT FROM THOSE NOW CONTEMPLATED, WHETHER OR NOT ARISING FROM PRESENTLY UNFORESEEN CONDITIONS WHICH THE ABOVE NAMED DOCTOR OR HIS/HER ASSOCIATES OR ASSISTANTS MAY CONSIDER NECESSARY OR ADVISABLE IN THE COURSE OF THE PROCEDURE.
3. THE NATURE AND PURPOSE OF THE PROCEDURE, POSSIBLE ALTERNATIVE METHODS OF TREATMENT, THE RISK AND BENEFITS INVOLVED, AND THE COURSE OF RECUPERATION HAVE BEEN FULLY EXPLAINED TO ME. NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN BY ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED.
4. I UNDERSTAND AND AGREE WITH THE ABOVE INFORMATION. I HAVE NO QUESTIONS, WHICH HAVE NOT BEEN ANSWERED TO MY FULL SATISFACTION. I UNDERSTAND THAT I HAVE THE RIGHT TO ASK FOR FURTHER INFORMATION BEFORE SIGNING THIS CONSENT. I HAVE CROSSED OUT ANY PARAGRAPH OR SENTENCE ABOVE WHICH DOES NOT APPLY OR TO WHICH I DO NOT GIVE CONSENT.

PATIENT SIGNATURE:_____
(OR PARENT OR GUARDIAN IF PATIENT IS UNDER 18 OF YEARS OF AGE)

WITNESS SIGNATURE:_____
(OF PATIENT, PARENT OR GUARDIAN SIGNATURE)

PHYSICIANS' / DENTIST'S STATEMENT OF INFORMED CONSENT

I HAVE EXPLAINED TO THE PATIENT (OR PERSON AUTHORIZED TO CONSENT FOR THE PATIENT), THE NATURE OF THE CONDITION(S) WHICH APPEAR INDICATED BY DIAGNOSTIC STUDY. IN ADDITION TO ADVISING OF POSSIBLE ALTERNATIVE MODES OF TREATMENT, I HAVE EXPLAINED, IN LAYMEN'S TERMS, THE POSSIBLE RISK(S), HAZARDS, COMPLICATIONS AND CONSEQUENCES WHICH ARE, OR MAY BE, ASSOCIATED WITH THE PROCEDURE(S). THE PATIENT, OR OTHER INDIVIDUAL WHOSE SIGNATURE IS SHOWN, HAS INDICATED HIS/HER UNDERSTANDING, HAS CONSENTED TO THE PERFORMANCE THEREOF, AND HAS STATED THAT NO FURTHER EXPLANATION WAS DESIRED.

PHYSICIAN/DENTIST SIGNATURE:_____