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CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any surgical procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize ***Donald I. Galen, M.D.*** and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him to perform the following (IN MEDICAL TERMS KNOWN AS): Acessa Radiofrequency Uterine Fibroid Ablation

(IN COMMON TERMS KNOWN AS):
Acessa Laparoscopic Ablation of Symptomatic Uterine Fibroids

and/or to do any other procedures that, in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

GENERAL RISKS AND COMPLICATIONS. I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which have been described to me. These risks include bleeding, infection, anesthesia risks, pain and death.

SPECIFIC RISKS AND COMPLICATIONS. I am satisfied with my understanding of specific risks of this procedure or treatment including bleeding, infection, injury to bowel, bladder or ureter, anesthesia risks, inability to treat all uterine fibroids, possible need for an open abdominal incision, need for further surgery, recurrence of uterine fibroids, no relief of symptoms, pain.

ALTERNATIVE METHODS OF TREATMENT. I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including open abdominal or laparoscopic myomectomy, uterine artery embolization, hysterectomy, medical (pharmacologic) treatment, etc.

NO TREATMENT. I am satisfied with my understanding of possible consequences, outcomes or risks if no treatment is rendered.

SECOND OPINION. I have been offered the opportunity to seek a second opinion concerning the proposed treatment /procedure.

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE OR TREATMENT. I understand that conditions may arise which are unforeseen at this time, and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

OTHER SERVICES. I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.

PHOTOGRAPHY. I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use.

NO GUARANTEES. I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful outcome.

OTHER QUESTIONS. I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

DATE_____ TIME_____

PATIENT NAME:_____

PATIENT SIGNATURE:_____

PHYSICIAN SIGNATURE:_____

WITNESS:_____