PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND ACKNOWLEDGMENT OF RECEIPT OF MEDICAL INFORMATION

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208-229-2368

IMPORTANT INFORMATION ABOUT THIS DOCUMENT Read Carefully Before Signing

TO THE PATIENT:

You have been told that you should consider medical treatment or surgery. The Idaho law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment or surgery, (3) the risks of the proposed treatment or surgery (4) reasonable therapeutic alternatives and material risks associated with such alternatives.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risk and hazards involved.

In keeping with the Idaho Law of Informed Consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

1. Patient Name: _____
2. Treatment or Procedure: _____
   A. Description, nature of the treatment or procedure: _____
   B. Purpose: _____
3. Patient Condition: Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in item number 2 is indicated and recommended:

   _____

   _____
4. Material Risks of Treatment or Procedure:
   A. All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.
      ☐ See attachment for risks determined by your doctor.
   B. Additional risks (if any) particular to the patient because of a complicating medical condition are: _____

      _____
   C. Risks generally associated with any surgical treatment or procedure, including anesthesia are: death, brain damage, disfiguring scars, quadriplegia (paralysis from the neck down), paraplegia (paralysis from the waist down), the loss or loss of function of any organ or limb, infection, bleeding and pain.
5. Reasonable therapeutic alternatives and risks associated with such alternatives are: _____

   _____

ACKNOWLEDGMENT AUTHORIZATION AND CONSENT

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No Guarantee: All information given to me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures or as to prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated, and therefore, there is and can be no guarantee, either express or implied, as to the success of other results of the medical treatment or surgical procedure.

Additional Information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

Particular Concerns: I have had an opportunity to disclose to and discuss with the physician providing such information those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

Questions: I have had an opportunity to ask, and I have asked any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

Authorized Physician: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedure or other therapy described in item 2 is:
Physician Certification: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the Patient, or the Patient's Representative, concerning the Medical Treatment or Surgical Procedure, to the best of my ability.

_____ _____
Signature of Physician Date/Time

CONSENT

Consent: I hereby authorize and direct the designated authorized physician or group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in Item 2 of this Consent Form, including any additional procedure or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure described in Item 2 of this Consent Form, including risks or alternatives and acknowledge that my questions have been answered to my satisfaction.

_____ _____
Signature of Witness Date/Time

_____ _____
Patient or Authorized Party Date/Time

Relationship: _____ If consent is signed by someone other than the patient, state the reason:

_____