SEGMDPC

420 W 23RD ST SUITE PB
NEW YORK, NY 10011

NAME: [redacted]
DOB: [redacted]

Date: 8/27/19
Time: 11:36 (AM)/PM

CONSENT FORM (to be signed by patient wherever applicable)
PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT

1. I hereby authorize Dr. Goldstone or associates or assistants of his/her choice at LASER SURGERY CARE LSC to perform upon me/the named above patient the operation(s) and/or procedure(s) HRA w/ possible biopsy
   ✓ Check if applicable including such photography, videotaping, televising, or other observation of the operation(s) procedure(s) as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity remain anonymous and all photographs and videotapes remain the property LSC.

2. The nature and purposes of the operation/procedure has been explained to me and I have been informed of the expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternative to the proposed treatment, including no treatment. I have been given opportunity to ask questions and all my questions have been answered fully and satisfactorily.
3. It has been explained to me that during the course of an operation unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) set forth in paragraph 1. I therefore authorize and request that the above named surgeon, his associates, and/or assistants perform such related surgical procedure(s) and administer whatever is necessary and desirable in the exercise of their professional judgement.
4. I have been informed that there are other risks, hazards, complications, and consequences that are attendant to the performance of any surgical procedure. I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation, treatment(s), or procedure(s).
5. I further consent to the administration of such anesthesia and/or blood transfusions as may be considered necessary. I recognize that there are always risks to life and health associated with anesthesia and blood transfusions and such risks have been explained to me.
6. I further consent to disposal by hospital authorities, or possible use for research purposes, in accordance with its accustomed practice, of any tissue(s) or parts which may be removed.
7. I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.

Signature [signature]

Print Patient Name [redacted] Date 8/27/19

Witness Signature [signature]

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure operation, have offered to answer any questions, and have fully answered such questions. I believe that the patient/relative guardian fully understand what I have explained and answered.

Provider Signature [signature] Date 8.27.19

Print Name [illegible]