KANSAS PEDIATRIC NEUROLOGY

# PROCEDURE AND/OR MINOR SURGERY CONSENT FORM

Patient Name: _____ DOB: _____ FIN: _____

1. I hereby grant consent to Dr. _____ and whomever he/she may designate as his/ner assistants to perform upon _____ the following operation procedures:

_____

_____

2. I have been informed and understand the nature and purpose of the operation, the probable consequences thereof, the possible alternative methods of treatment, and the probable risk of hazards involved. The possibility of assurance and complications has been explained and is understood by me and I acknowledged that no guarantee or assurance has been made as to the results to be attained.
3. It has been explained to me that during the course of the operation unforeseen conditions can be revealed that necessitate the extension of the initial procedure of a different procedure than that set earth above. I therefore authorize and request the above named physician or his designated consultants to perform such procedures that are and his judgment necessary aid desirable.
4. I consent to the administration of anesthesia by or under the direction of staff anesthesiologist or physician and the use of such anesthetics as he/she may deem advisable for the above operation procedure, except

_____

(NONE, SPINAL ANESTHESIA; OR OTHER)

5. I also consent to the study and retention or disposal on tissue or body pasts dr organs which may be removed during the above operation or procedure.

_____ _____

Patient Signature Witness

_____ _____

Parents or Guardian's Signature' for minor or Incompetent person Witness

Date _____ Time _____ am/pm

Authorization must be signed by the patient, or by the nearest relative in the case of a minor; or when patient is physically or mentally Incompetent, This authorization shall be considered valid for 30 days provided the diagnosis, procedure and risk have not changed from the date of consent.

# STATEMENT OF RESPONSIBILITY

Dear Patient,

Your Primary Care Physician is the coordinator of your medical care. As part of your medical plan and in order to be eligible for the maximum benefits under your plan, services received from a provider other than your primary care physician require a written referral. If you do not obtain a referral, you may be financially responsible for all or part of the charges for services received.

# PATIENT RESPONSIBILITY FOR PAYMENT

I understand that I may be financially responsible for all or part of the charges for services received if I elect to receive services from a Referral Provider without a referral authorization from my Primary Care Physician.

If you have questions about your coverage, please contact your plan's Customer Service Department.

Parent/Guardian _____

Member Signature _____

Clinic Representative _____

**PLEASE FORWARD THIS TO THE BUSINESS OFFICE DOCUMENT ROOM**