INFORMED CONSENT FOR OFFICE PROCEDURE

Name:_____ DOB:_____ Account #:_____

Optometric Physician:_____

I hereby authorize my optometric physician, listed above, and such assistants that he/she may designate, to perform on me the following procedure:

_____

_____

_____

❑ Right Eye ❑ Left Eye

The nature of the procedure and its purpose has been explained to me and I understand them. I have also had explained to me and understand the recognized alternatives to this procedure. I recognize that during the course of the procedure, unforeseen conditions may arise and that there are certain potential serious risks and complications with this procedure. I have been informed of the anticipated results as well as these risks and acknowledge that no guarantees have been offered to me as to the outcome of the procedure. I have discussed the procedure at length with my doctor.

I consent to the administration of anesthesia and/or such drugs as may be necessary. I understand that all anesthetics involve risks of complications, serious injury, or rarely death, from both known and unknown causes.

Additional Physician Comments:_____

_____

I have read and understand this consent and have had all my questions answered to my satisfaction and wish to have this procedure performed by my physician. I understand that I am free to withhold or withdraw consent to this proposed procedure at any time.

_____ _____

Patient/Legally Responsible Person Signature *Relationship of legally responsible person to patient*

_____

Date