Last Name_____

ALI HENDI, MD, PC
HENDI AMBULATORY SURGERY CENTER, PC

CONSENT FOR TREATMENT

I, _____, agree to the performance of Mohs micrographic surgery and reconstructive surgery as needed / excision and reconstructive surgery as needed at the site(s) of:_____ by my physician, **Ali Hendi, M.D.** and such others he considers necessary. Medical trainees/observers may be present, but will not directly participate in my care.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures that are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

The risks and benefits of the procedure have been explained to me. The risks include, but are not limited to: bleeding, pain, bruising, swelling, infection, nerve damage, prominent scar that may require further surgery and possible tumor recurrence. No guarantee or assurance of results can be made. Additional specific risks may include: _____

I understand that there are certain medical and surgical alternatives available and I have been given information regarding other feasible forms of care.

I understand that only local anesthesia (the application of local anesthetic agents, by injection, in appropriate doses adjusted for weight), will be used.

I permit photographs of me to be taken for documentation, educational and teaching purposes during the course of my outpatient treatment. The photographs and information relating to my case may be published or used for any other professional purpose.

I authorize the review of my medical records by a non-staff physician (peer reviewer) in the interest of improving patient care. I have/will notify Dr. Hendi or his staff about any advanced directives that could affect my care. I am aware there is a practice grievance policy on file which I have the right to view.

My signature below constitutes acknowledgement (1) that I have read and understand all of the above; (2) that all questions I have regarding my condition and the excision procedure have been answered to my satisfaction; (3) that the operation has been adequately explained by Dr. Hendi or one of his assistants; (4) that I voluntarily, and knowingly give my signed authorization for this procedure.

_____ Signature of Patient

_____ Signature of Witness

_____Date and Time of Surgery