DR GAVIN M DAVISON
orchard park aesthetics

3680 Eggert Road | Orchard Park, NY 1412
Phone: (716) 932-1313 | www.opaesthetics.com

Patient Name:_____ DOB: _____

Primary Insurance:

Referring MD:_____ Referring MD Phone:_____

Encounter Date:

Authorization for Medical and/or Surgical Treatment

I, _____ , (if acting on behalf of the patient, specify relationship _____) hereby authorize and give my consent to Dr. Davison and his assistant(s), including staff and employees of Dr. Gavin M. Davison, MD, PLLC, under his/her direction to perform me/patient _____ the following operation(s)/procedure(s):

_____

_____

_____

which is, in non-technical language (designate, where appropriate, Left or Right):

_____

_____

_____

I acknowledge that the operations(s)/procedures(s), their alternative and reasonable foreseeable risks and benefits (check one):

_____ (initial) I have been explained to me; and I have been given the opportunity to ask questions; and all my questions have been answered fully and satisfactorily in understandable terms.

_____ (initial) I understand and accept the most likely risks and complications that include, but are not limited to: infection, Uneven Pigmentation, Depigmentation, Hypo Pigmentation, Keloid Scarring, Scar, Redness, Lumps under the skin, Peeling, Swelling, Bruising, and Asymmetry.

_____ (initial) I understand that during the course of the operations(s)/procedure(s) unforeseen conditions may arise which necessitate procedures different from those contemplated and therefore, I consent to the performance of additional operation(s)/procedure(s) which the above named physician may consider necessary in his/her medical judgment.

I consent to the administration of such anesthesia as may be considered necessary or advisable in the judgment of the physician responsible for administration of anesthesia in my case, with the following exception (if no exception, state NONE):

_____

I understand that some of the staff may be physicians, dentist, nurses, and other healthcare professionals in training and under the supervision of the attending physician/dentist or the anesthesiologist. I understand that any organ or tissues surgically removed may be examined and retained by Dr. Gavin M. Davison, M.D., PLLC, for medical, scientific, or educational purposes and such organs or tissues may be disposed of in accordance with customary practice and as required by laws.

I permit photography, videotaping, televising, or other observation of this operation(s)/procedure(s) provided that my identity will remain anonymous. I understand that this is for the sole purpose of advancing the education the education and research purposes of the facility and/or my physician(s)/dentist(s)/healthcare professional (s), and the resulting photography or videotape will not be sold or

used commercially. I agree that such photographs or video recordings shall be the sole property of the facility and/or my physician(s)/dentist(s)/healthcare professional(s).

I acknowledge that no guarantee or assurance have been made to me concerning the results of this operation(s)/procedure(s).

I acknowledge that I have read this consent form in its entirety or it has been read to me, and the questions I have about it have been asked and answered and I signed it with full knowledge of its contents. All blank spaces have been completed and any paragraphs or words which do not pertain to me or to which I do not consent have been crossed out prior to signing.

Patient/Parent/Agent/Guardian_____ Date_____ Witness_____ Date_____

Interpreter (if used)_____ Date_____ Witness_____ Date_____

NOTE: If the individual signing is the Health Care Agent or Guardian, he/she must provide written documentation to evidence his/her legal authority to consent. A copy of the documentation must be placed in the patient's medical record.

PHYSICIAN ATTESTATION (to be signed on the date of surgery/procedure)

I hereby attest to the accuracy and completeness of the information contained in this form, including description of the operation(s)/procedure(s).

Physician Name (Print)_____

Physician Signature_____