

**Surgical/Diagnostic/Therapeutic Consent**

I, \_\_\_\_\_, acknowledge that I have authorized and directed my physician, \_\_\_\_\_, and his/her choice of associates, assistants, and appropriate health care providers to perform the following operation or diagnostic procedure on me:

\_\_\_\_\_ and/  
or such other operation(s) or therapeutic procedure, which they deem necessary or advisable. **It is understood that my sperm will be transferred to the RMG ART Laboratories, Inc. for evaluation, preparation and storage until the time my partner has her A.R.T. procedures or for a maximum of two (2) years.**

The procedure(s) has/have been explained to me by my physician and I attest to the following:

1. I understand that the nature and purpose of the procedure and risks involved may involve serious consequences.
2. I have been informed of the possible medically accepted alternative methods of treatment. I understand the substantial risks, dangers and possible consequences of such alternatives (including no procedure or treatment).
3. I recognize that there are other risks during my care, such as bleeding, allergic reaction, infection, loss of use of body parts, and/or life.
4. I acknowledge that I have a general understanding of the operation or procedure and the reason for its use.
5. I acknowledge that no promises can be given that the procedure will be successful and no guarantee of success or cure has been given to me.
6. I grant my physician and his/her associates, assistants, and appropriate healthcare providers permission to perform additional procedures, which in their judgment may become necessary during this procedure.
7. I consent to other medical services, which the above named physician deems necessary or advisable, including but not limited to, nursing, radiology, pathology and laboratory. I consent to medical services that are necessary for my total surgical experience that will be provided by employees of RMG IVF/Surgery Center.
8. I understand that the anesthesiologist and nurse anesthetists are not employees of RMG IVF/Surgery Center. I acknowledge anesthesia, analgesia and sedation may be required in connection with this procedure and understand that anesthesia/sedation involve certain risks and hazards. I authorize the anesthesia/sedation provider to administer anesthesia/sedation as required and indicated for the relief and protection of pain during the procedure. I recognize the plan of care may have to be changed without explanation to me.
9. I understand that the RMG IVF/Surgery Center is an Ambulatory Surgery Center and does not provide 24-hour care. If my physician and/or anesthesia practitioner find it necessary or advisable to transfer me to a hospital, I authorize RMG IVF/Surgery Center employees to arrange for and affect this transfer. Additionally, I authorize for information to be communicated to the transferring facility for continuity of care as well as the Center receiving a copy of the Discharge Summary or Summary Notes from the transferring facility in accordance with the Health Insurance Portability and Accounting Act of 1996.
10. \_\_\_\_\_ I voluntarily consent to blood transfusions and the use of blood products if deemed necessary by my physician. My physician explained to me the transfusion procedure, the probability that it will be required, and the inherent risks in the blood transfusion procedure. I understand that there are risks and benefits of, and alternatives to, blood transfusion and the use of blood products. The following are some, but not all, of the potential risks that can occur; fever and allergic reactions; hemolytic reaction; transmission of diseases such as hepatitis; AIDS; cytomegalovirus (CMV); bacterial infection; or other viruses. This list does not include all risks, but does address the most significant. **(If blood is refused strike through section 10 of this form.** The Refusal of Blood and/or Blood Products Form is required and must be signed when blood is refused).
11. I authorize the physician or pathologist to use his or her discretion in preserving for scientific or teaching purposes or to dispose of any removed tissue, body parts, organs, or devices/implantables consistent with RMG IVF/Surgery Center policy and state and federal regulations.
12. I understand that RMG IVF/Surgery Center may allow persons to be present during my procedure who are not directly involved in the procedure. I authorize one or more observers including but not limited to students, manufacturers representatives, and peer physicians to be present in the Operation Room and/or during other phases of my surgical admission.

13. I understand that all medical students and/or residents will solely be assisting with my surgical procedure and my surgeon will remain totally responsible for and in control of the operation and care. It is understood that I have the right at any time to request that any or all students and/or residents/fellows do not participate with my direct care.
14. I understand that photographs/videos of my procedure may be taken for scientific or teaching purposes, as long as my name is not revealed and no one able to identify me. I consent to the taking of these photographs/videos. I also understand that my physician may request photographs to be taken of my procedure and that these photographs may become part of my medical record. I authorize this photography and insertion of them in my medical record.
15. I agree and authorize that the facility may disclose portion(s) of the patient's record, including his/her medical records, to any person, corporation or other entity that may be liable for all or any portion of the facility charges. This includes, but is not limited to, insurance companies, health care service plans, worker's compensation carriers, laboratories, and radiology providers.
16. I have been provided information regarding the ownership of the RMG IVF/Surgery Center and advised that I have the right to have my surgery performed at any other facility offering similar services where my physician has privileges.
17. I am aware that at any time I do not understand or have concerns regarding any services being provided by the personnel of RMG IVF/Surgery Center, my physician or my anesthesia providers, it is my responsibility to make those questions and/or concerns known to the personnel and/or physicians.
18. I understand that I have the right to refuse any medical and surgical procedures and treatment.

**The undersign certifies that he/she has read the above and is the patient having surgery, the patient's legal representative, or is duly authorized by the patient as their general agent to execute this agreement and to consent to accept it's terms.**

\_\_\_\_\_  
SIGNATURE OF PATIENT \_\_\_\_\_  
DATE

PATIENT IS:  
( ) MINOR ( ) INCAPACITATED ( ) PYHSCALLY UNABLE TO SIGN ( ) OTHER \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF: \_\_\_\_\_  
DATE  
( ) PARENT ( ) LEGAL GUARDIAN ( ) POWER OF ATTORNEY  
( ) PATIENT REPRESENTATIVE/HIPPA

\_\_\_\_\_  
SIGNATURE OF WITNESS \_\_\_\_\_  
DATE

- I have asked all of the questions that I thought were important in deciding whether or not to undergo treatment or procedures. All of my questions have been answered to my satisfaction.
- I/we have questions that I/we would like to discuss with my physician prior to the surgery.

**TO BE SIGNED BY ATTENDING PHYSICIAN/SURGEON PRIOR TO BEGINNING PROCEDURE:**  
I have explained the procedure(s) as indicated on the facility consent to the patient and/or legal representative including but not limited to the specific indications for the procedure(s), alternatives to the procedure(s), possible adverse outcomes, risks and complications to the procedure(s). I understand that informed consent is my responsibility as the attending physician/surgeon.

\_\_\_\_\_  
PHYSICIAN/SURGEON \_\_\_\_\_  
DATE \_\_\_\_\_  
TIME

My physician has discussed my questions and/or with me and they have been answered to my satisfaction and I want to Proceed with my surgery as above.

\_\_\_\_\_  
PATIENT/LEGAL REPRESENTATIVE \_\_\_\_\_  
WITNESS