**OMEGA HEIGHTS FAMILY MEDICINE CLINIC, PLLC**

**CONSENT TO PERFORM IN OFFICE PROCEDURE**

My health care provider has answered any questions I have regarding the procedure ------------------------------------------------------------------------------------------------- and has given me information with the risks and benefits of the procedure. The benefits include:

a.--------------------------------------------------------------------------

b----------------------------------------------------------------------

c-----------------------------------------------------------------------

The risks/ complications of the procedure include:

1. ----------------------------------------------------------------------
2. -----------------------------------------------------------------------
3. -------------------------------------------------------------------------

I agree to have the procedure performed and will notify the clinic immediately if any complications arise

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

(Or signature of legally authorized representative)

If legal representative, indicate relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Certification**

I certify that the named person above has been given the information about the risks, benefits and complications of the procedure above.

Provider Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_