CONSENT FOR SURGICAL PROCEDURES

A. Hassan, M.D., F.A.C.S.

1) I authorize Doctor Hassan to perform the following procedure _____ _____ upon _____ _____ at Suite1, 2011 Union Blvd., Bay Shore, NY on _____. This operation is for the treatment of _____.
2) The nature and effect of the operation to be performed, risks involved, as well as possible alternative methods of treatment have been fully explained to me.
3) The fee for this procedure will be determined by agreement between my insurance company and the surgeon. Any amounts which my insurance company says I owe will be paid by me. This is also authorization for the operating surgeon to take, or direct to be taken, any photography required for the completion of records for this case. It is understood that these photographs will not be published in any form, with the possible exception of a medical journal.
4) I also authorize the operating surgeon to perform any other procedures which he may deem desirable in attempting to improve the condition stated in paragraph one, or any unforeseen condition that he may encounter during the operation.
5) I consent to the administration of anesthesia.
6) I know that the practice of medicine and surgery is not an exact science, and that therefore reputable practitioners cannot guarantee results. No guarantee or assurance has been given to anyone as to the results that may be obtained.
7) It is to be understood that if for any urgent reasons the surgeon is not able to complete the operation, then such completion will be done by one of the assistants and/or associates. It is further understood that if the surgeon is not able to begin the surgery as contemplated, that no surgery will be attempted by any associate without specific permission of the patient or authorized guardian. In addition, post-operative care will be administered by the operating surgeon or his associates or assistants.
8) All specimens must be sent to a laboratory for microscopic diagnosis. There will be a charge by the laboratory, which I, the patient agree to pay. This may be reimbursed, depending on the type of insurance coverage I have.
9) I understand that included in my fee for the above surgery is suture removal and post-operative care for a period of one year from the time of surgery unless you have an HMO insurance company in which doctors participate. The post-operative care is to include treatment for reasonable and customary services needed with reference to the type of operative care that I have authorized.

SIGNED: _____ DATE: _____

(patient or person authorized to sign consent for patient)

WITNESS: _____