visionary eye care

CONSENT FOR PROCEDURE

Patient Name: ____

I authorize and direct F. Fred Hidaji, M.D. and the assistants of his choice to perform the following procedure:

Dr. Hidaji has discussed the following with me *(please initial each line):*

___Nature and purpose of the procedure to be performed.

___Alternative methods of treatment to the planned procedure.

___Possibility of vision loss, infection, scarring, and bleeding due to the procedure.

___Consequences if treatment is not received.

___What to expect to surgery can be variable, and no guarantee is made as to the results.

___A re-operation may be needed to correct an unsatisfactory result.

___Advance directives (e.g. Do Not Resuscitate orders) are suspended for the procedure.

I authorize F. Fred Hidaji, M.D. to provide and/or arrange for the provision of such additional services as he deems reasonable and necessary including, but not limited to, pathology and radiology. Any tissues, blood specimens, or other parts surgically removed may be retained or disposed of by the hospital or Dr. Hidaji's office in accordance with its accustomed practice.

I authorize F. Fred Hidaji, M.D. to administer sedation and anesthesia. The alternatives to and risks of sedation/anesthesia administration have been fully explained and discussed with me by my physician or his designee.

I also consent to the observation and/or participation in the procedure by appropriate medical personnel permitted by my physician and authorized by the hospital, and to non-identifying films or photographs that my physician may take or request.

My signature below indicates that:

- **I have read and understand this Consent form**
- **I have given consent for the above procedure, and that all of my questions about the procedure have been answered in a satisfactory manner.**

______________________________	______________________________
Patient/Parent/Legal Guardian Signature	**Today's Date and Time**
______________________________	______________________________
Relationship of Person Signing for patient	**Signature/Title of Witness**
______________________________	
Physician's Signature	