

**DISC SURGERY CENTER AT NEWPORT BEACH**  
**Consent to Medical or Surgical Care and Treatment**



Patient Name \_\_\_\_\_  
Surgeons Name \_\_\_\_\_  
Date of Surgery \_\_\_\_\_

I authorize \_\_\_\_\_ and such physicians, assistants, or other personnel of the hospital or medical facility chosen by him, or that you have previously seen, to perform the following (IN MEDICAL TERMS KNOWN AS):

And/or to do any other procedures that in their judgment may be advisable to my well being, including such procedures that are considered medically advisable to remedy conditions discovered during the above procedure. Preoperative evaluations will need to be obtained by a medical physician.

NOTE TO PATIENT: There are inherent risks involved in any surgical procedure or treatment programs. IT is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment. Medicine and surgery are generally safe and helpful. However, medical or surgical procedures of any type involve the taking of risks, ranging from minor to serious (including the risk of death). It is important to be aware of the following possible risks before receiving the treatment you and your physician are planning.

GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment or procedure. These risks include, but are not necessarily limited to: bleeding, infection, pain, injury to the nerves and blood vessels with subsequent dysfunction, thrombophlebitis and blood clot formation, stiffness in the extremity and decreased range of motion, weakness in the extremity and possible paralysis, injury to other adjacent body organs, wound healing problems, adverse drug and anesthesia reactions, and even death. Such medically unrelated conditions as heart attack, lung failure, liver failure, stroke, and gallstones may occur in association with the operation. If a metallic implant or other type of orthopedic device is used, there may be untoward reaction to that substance. On occasion the orthopedic hardware may fail, loosen, or dislocate, or may need to be removed. I fully understand that my condition may become worse as a result of the operation because of any one of the conditions mentioned above. I also understand that if I have cosmetic implants of any type, Dr. \_\_\_\_\_ and his associates cannot assume responsibility for damage, dislodgement or rupture of cosmetic implants during surgery.

Intl \_\_\_\_\_

**DISC SURGERY CENTER AT NEWPORT BEACH**  
**Consent to Medical or Surgical Care and Treatment**



Page 2

INSURANCE: I understand any insurance coverage I have is a contract between the insurance company and myself. I accept full responsibility for verification of coverage of any involved personnel in my care. The physician does not act as the agent for any arrangements, nor is he responsible for any other providers or their fees. I understand any or all amounts not covered by my insurance carrier are my full responsibility unless otherwise arranged in written contract. Insurance is billed as a courtesy to the patient.

SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of the specific risks and complications of this procedure and treatment, as reviewed with me by my treating physician.

PROPOSITION 65 WARNING STATEMENT: **“WARNING: Some products used during surgery contain chemicals known to the State of California to cause cancer, birth defects or other reproductive harm.”** The State of California has listed over 800 chemicals under Proposition 65. Some of these chemicals can be found in the manufacturing and sterilization of products used during surgery.

ALTERNATIVE METHODS OF TREATMENT: I am satisfied with my understanding of alternative procedures or treatment and their possible benefits and risks. This would include rest modification in my activity level, appropriate bracing of the injured area, the use of anti-inflammatory medication, and physiotherapy.

ALTERNATIVE SURGERY: I understand that other forms of surgery may be available. The procedure planned, the reasons and surgical alternatives have been reviewed in full and I understand them. I realize that if one procedure does not result in the desired result, further or different surgeries may be necessary.

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes, or risks if no treatment is rendered.

SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the proposed treatment procedure. This may be obtained if desired.

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT:  
I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

OTHER SERVICES: I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.

Intl \_\_\_\_\_

**DISC SURGERY CENTER AT NEWPORT BEACH**  
**Consent to Medical or Surgical Care and Treatment**



Page 3

**PHOTOGRAPHY:** I consent to the photographing, filming, or videotaping of the treatment or procedure for educational or diagnostic use. I consent to the projection of image to the pre-op and PACU area.

**OBSERVER:** My physician may have an observer witnessing and/or a company representative may be required by my physician to view the procedure.

**NO GUARANTEES:** I fully understand that there are risks involved in any procedure or treatment and it is not possible to guarantee or give assurance of a successful result.

**OTHER QUESTIONS:** I am satisfied with my understanding of the nature of the procedure or treatments, and all of my additional questions about the treatment or procedure have been answered.

DATE \_\_\_\_\_

TIME: \_\_\_\_\_: \_\_\_\_\_ AM / PM

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
WITNESS

TRANSLATED (IF APPLICABLE): \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_