Roy M. Brooks, MD
Asha Barrett, MD
Andrew B. Block, MD
Eric Ashkin, MD
Julie G. Glass, MD
Ronald D. Jacobs, MD
Gayle F. Friedman, MD
Lauren F. Ng, MD
Anne Seifert, CNM.
Meredith Tussing, WHNP

CAPITAL WOMEN'S CARE
Working Together for Women's Health

AUTHORIZATION AND CONSENT TO SURGERY
DIAGNOSTIC OR THERAPEUTIC PROCEDURES

Patient: _____ Age: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

I authorize Dr. _____, or one of their associates, to perform the operation(s) or procedure(s) listed below, including any incidental procedure(s) and/or additional services (including but not limited to, anesthesia, radiology, pathology, laboratory studies, treatment of complications, surgical photographs) as may be necessary.

_____

_____

I have been informed, and understand, the proposed operation or procedure that will be performed. I understand the purpose of the operation(s) or procedure(s) as well as the complications and risks. My doctor has informed me of the alternative surgical and/or medical treatment if applicable. It has been explained to me that my doctor cannot inform me of every complication that could occur but that bleeding, perforation of an organ, failure of purpose from unknown causes and death, even though are rare, are potential complications of the operation or procedure. I also have been informed that the use of an anesthetic may be necessary for the surgery and/or procedure and that there are risks and complications associated with anesthesia. I have been advised by my doctor to discuss these risks with the anesthesiologist before my operation and/or procedure. Furthermore, if the transfusion of blood or blood products is required during or after the surgery and/or procedure, the possibility of transmission of the AIDS virus and/or Hepatitis is also a risk.

I have been given satisfactory explanations and information to the level of knowledge for which I desire, and have been given an opportunity to ask any questions.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

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INSURANCE VERIFICATION FOR SURGERY AND/OR PROCEDURES

My signature on this form acknowledges the fact that I have consented to have Dr._____ perform surgery on me. I fully understand that the insurance verification, second opinion and precertification are the responsibility of the patient, and any penalty in relation to such problems, which result in a lower reimbursement to the doctor, is solely my responsibility. I also understand that any denial from the insurance company in reference to pre-existing conditions will also be my responsibility. All questions regarding the above-mentioned insurance procedures have been discussed and answered to my satisfaction.

_____ _____
Printed Name (Patient or Authorized Agent) Relationship

_____ _____
Signature (Patient or Authorized Agent) Relationship

_____
Street Address

_____
City State Zip

_____
Date

7350 Van Dusen Road
Suite #330
Laurel, Maryland 20707
(301) 468-0073

2101 Medical Park Drive
Suite #200E
Silver Spring, Maryland 20902
(301) 468-0073

121 Congressional Lane
Suite #100
Rockville, Maryland 20852
(301) 468-0073