MARTINEZ EYE ASSOCIATES

Disclosure and Consent for Medical and Surgical Procedures

You have the right as a patient to be informed about your condition and the recommended medical, surgical or diagnostic procedure to be used to treat or diagnose such condition so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I(We) voluntarily request Dr. **Dr.** as my eyecare provider and such associates, technical assistants and other healthcare providers as they may deem necessary, to treat my condition which has been explained to me as:
For which I have elected to undergo the procedure explained to me as:

I(We) understand that my doctor may discover other or different conditions which require additional or different procedures than those planned. I(We) authorize my doctor and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment .
I(We) understand that no warranty or guarantee has been made to me as to result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedure(s) planned for me.
I(We) realize that common to surgical, medical and diagnostic procedures is the potential for infection and allergic reactions. I(We) also realize that the following risks and hazards may occur in connection with this particular procedure:

- ☐ **Infection**
- ☐ **Allergic Reaction**
- ☐ **Inflammation**
- ☐ **Permanent Vision Loss**
- ☐ **Temporary Vision Loss**
- ☐ **Post Operative Pain and Discomfort**
- ☐ **Scarring**

I(We) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I(We) understand that certain complications may result from the use of any anesthetics including respiratory problems and drug reaction. I(We) have been given the opportunity to ask questions about my condition, alternative forms of treatments, risks of non treatment, the procedure to be used, and the risks and hazards involved, and I(We) believe that I(we) have sufficient information to give this informed consent.
I(We) certify that this form has been fully explained to me/us that, I (We) have read it or had it read to me/us, that the blank spaces have been filled in and that I (We) understand it's contents.

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Signature of patient or person acting on patient's behalf

_____ **07/07/2010**
Signature of Physician Date