PROVIDENCE
Health & Services
Providence Holy Cross Medical Center
Providence Saint Joseph Medical Center
Providence Tarzana Medical Center

CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Dr._____ and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him or her to perform the following (IN MEDICAL TERMS KNOWN AS):

- Laser Tattoo Removal

(IN COMMON TERMS KNOWN AS):

- Laser Tattoo Removal

and/or to so any other procedure that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

- **GENERAL RISKS AND COMPLICATIONS**: I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described generally on the back of this form. These risk include the risk of bleeding, infection, pain, anesthesia risks and death.
- **SPECIFIC RISKS AND COMPLICATIONS:** I am satisfied with my understanding of specific risks of this procedure or treatment including (Doctor to describe specific risks where applicable):
  - **Hair loss, Blisters, Scarring, Hypo-pigmentation, Hyper-pigmentation, If pregnant or breast-feeding, If patient is on medication and does not inform staff prior to procedure.**
- **ALTERNATIVE METHODS OF TREATMENT:** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including (Doctor to describe specific alternative procedures and complications where applicable):
  - **Hair loss, Blisters, Scarring, Hypo-pigmentation, Hyper-pigmentation, If pregnant or breast-feeding, If patient is on medication and does not inform staff prior to procedure.**
- **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 or procedure.
- **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.
- **PHOTOGRAPHY:** I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnosis use.
- **NO GUARANTEES:** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurances 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.

I have read, initialed and I understand all the risks involved

PRINT NAME: _____ **Signature**: _____ **Date**: _____
(Parent or Legal Guardian)

Translated (IF APPLICABLE) *Yes* ***or*** *No* ***Name of translator:*** _____

PHYSICIAN SIGNATURE: _____

WITNESS:_____