[COMPANY NAME/LOGO]

INFORMED CONSENT FORM FOR SURGICAL/PROCEDURAL
[PRACTICE NAME]

I _____ hereby consent to, and authorize [PHYSICIAN NAME], and such other assistants employed or contracted by [PRACTICE NAME] as he/she deems appropriate to perform the following procedure on me:
I understand that my medical care may require a pelvic (and/or rectal) examination defined as a series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include but need not be limited to, the health care provider's gloved hand or instrumentation.

I also consent to the performance of such additional procedures as may be deemed reasonable, appropriate and necessary, arising from presently unforeseen conditions, circumstances, or complications of this procedure.

My physician/provider has fully explained to me the nature and purpose of the procedure(s), the reasons for performing the procedure, the risks involved, the prospects for success, and possible alternative methods of treatment. I understand that there are both known and unforeseen risks to this procedure.

I consent to the analysis and disposal of any body tissues or parts which may be removed, in accordance with customary procedures.

I have been given the opportunity to ask questions of my physician/provider about my condition, alternative forms of treatment, risks of the planned procedures, risks of non-treatment, the procedures to be used and the risks and hazards involved and I believe that I have sufficient information to give this informed consent.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

Signature of
Patient/Parent/Guardian/Conservator:_____
(If other than patient, indicate relationship)

Date:_____ Time:_____ AM/PM

Witness to Signature:_____

Date:_____ Time:_____ AM/PM

I, the undersigned physician/provider, certify that I have explained the above described procedure(s) to the patient and/or nearest relative or legal guardian. To the best of m knowledge, this patient understands and comprehends these matters and consents to the performance of the procedure stated by me.

Physician/Provider Signature:_____

Date:_____ Time:_____ AM/PM

This office is compliant with and regulated by the Board of Medicine rule chapter 64B8 and 64B15, Florida Administrative Code.