



**GENERAL CONSENT FOR MEDICAL AND SURGICAL PROCEDURES**

You have been given information about your condition and the recommended surgical, medical, or diagnostic procedure(s) to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. Condition: Dr. \_\_\_\_\_ has explained to me that the following condition(s) exist in my case \_\_\_\_\_  
\_\_\_\_\_
  
2. Proposed Procedure(s): I understand that the procedure proposed for evaluating and treating my condition is:
  - Punctal Plugs
  - Lash Epilation
  - Probe & Irrigation
  - Foreign Body Removal
  - Chalazion Excision
  - Biopsy
  - Other
  
3. Risks/Benefits of Proposed Procedures: Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs.
  
4. Complications; Unforeseen Conditions; Results: I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that in the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.
  
5. Acknowledgements: Available alternatives, the potential benefits and risks of the proposed procedure(s), and the likely result have been explained to me. I understand what has been discussed with me as well as the content of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.
  
6. Financial Responsibility: I understand that this treatment is a separate billable procedure. I may be responsible to pay amounts applied to my deductible, co-pay, or co-insurance. I will be responsible to pay the entire charge if I do not have insurance or my insurance does not cover this procedure.
  
7. Consent to Procedure(s) and Treatment: Having read this form and talked with the physician, my signature below acknowledges that I voluntarily give my authorization and consent to the performance of the procedure(s) described above by my physician and/or his/her associates assisted by clinical personnel and other trained persons as well as the presence of observers.

\_\_\_\_\_  
**Patient (or person authorized to sign for patient)**

\_\_\_\_\_  
**Date**