



# Ponderosa Pediatrics

## Where Kids Come First

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### Patient Procedure / Operation Consent

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, authorize Dr. Mick or Dr. Hinton to perform the following operation or procedure: \_\_\_\_\_

I understand the reason for this operation / procedure is: \_\_\_\_\_

Alternatives include: \_\_\_\_\_

**RISKS:** This authorization is given with the understanding that any procedure or operation involves some risks and hazards. The more common risks of any procedure/operation include infection, bleeding and allergic reactions. These risks are serious and possibly fatal. Some of the significant risks of this particular procedure/operation are:

**NOTE TO PATIENT:** If you have any questions about the risks or hazards of the proposed procedure/operation, ask your physician before signing this form.

**FINANCIAL RESPONSIBILITY:** Patient (guarantor) is responsible for any and all charges not covered by the insurance company. All AHCCCS plans will not pay for circumcision procedure. The cost for this procedure is \$240.00 if paid in full prior to or at the time of procedure.

**PATIENT CONSENT:** I have read and understand the risks involved in this operation or procedure. I accept financial responsibility for any charges not covered by insurance, and I have had any and all questions explained to me.

\_\_\_\_\_  
Patient / Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**PHYSICIANS DECLARATION:** I have explained the contents of this document to the patient (guardian) and have answered all the patient's questions. To the best of my knowledge, the patient is adequately informed. The patient has consented.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date