APOLLO SURGERY CENTER

Attending Physician/Surgeon

Patient Name: Surgeon: Date of Service: Medical Record: Date of Birth: Age:

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the diagnosis or treatment of your condition. All surgical operations and diagnostic and therapeutic procedure involve risks of unsuccessful outcomes, complications, injury or even death, from both known and unforeseen causes. No warranties or guarantees have been made as to result or cure. Operation or procedure to be performed; Esophagogastroduodenoscopy with possible biopsy, polypectomy, dilation of stricture, tattooing, bleeding control, and/or therapeutics Colonoscopy with possible lieoscopy, biopsy, polypectomy, dilation of stricture, tattooing, bleeding control, and/or therapeutics Colonoscopy with possible lieoscopy, biopsy, polypectomy, dilation of stricture, tattooing, bleeding control, and/or therapeutics Vour treating physician may be an independent contractor and therefore is not an employee of Apolio Surgery Center ("Center"). Independent contractor physicians also provide anesthesia services at the Center. As a patient, you have the right to receive as much information as you may need in order to give informed consent or to refuse the recommended course of treatment. Except in emergencies, your healthcare provider should describe in language you can understand, the nature of the ailment and the or nature of the proposed treatment or procedure, the material risks or dangers involved, the ailmentae courses of treatment nontreatment, including the respective risk of unfortunate consequences associated with the treatment or procedure, and the relative probability of success of the treatment in procedure, and expected to consult your healthcare provider prior to giving your consent to such consult. You have the right to consent or refuse any proposed operation or procedure and the process of treatment nontreatment, including the respective risk of unfortunate consequences associated with the treatment or procedure prior to its performance. It is a process involved the air process of the process of the treatment or procedure, and having received and fully understanding the above, and having rece		
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Witness/Date Relationship. If Other Than Patient Signing		Person Legally Authorized To Consent for the Patient
		Relationship, If Other Than Patient Signing