Specialists In Reproductive Medicine & Surgery, P.A.

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Excellence, Experience & Ethics

General Consent Form

I have read the provided information on the following treatment(s)/procedure(s):

_____

_____

_____

I understand that SRMS is a medical practice pursuant to the rules and regulations of the Florida Board of Medicine. I understand that the practice of medicine is not an exact science. I understand that while my physician has recommended these operations, treatments and procedures for my condition, no guarantee can be made that they will be successful. I have also received information on alternative options for my particular situation, including no treatment. I have neither asked for nor received any guarantee or promises as to the results to be obtained.

I have read and understand the above patient information packet(s), and I have had an opportunity to ask questions regarding the above topic(s) and have had them answered to my satisfaction.

I accept the possibility of complications with the use of the medication(s) and/or the performance of particular procedure(s) and wish to proceed with the above treatment(s) and procedure(s). All of the blanks in this consent have been filled prior to the signing of the signatures below.

_____	___/___/___	_____	___/___/___
Patient	Date	Physician or ARNP	Date
_____	___/___/___	_____	___/___/___
Guardian (if necessary)	Date	Witness	Date

Updated 4/24/2000
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