Pediatric Care Specialists
1322 Eisenhower Boulevard
Johnstown, PA 15904
(814) 266-8840
(814) 266-2176 fax

# Medical and Surgical Consent

Patient Name: _____ DOB: _____Date:_____

I request and authorize _____ and or the associates and/or assistants of his/her choice to perform the following procedure:

_____

Dr. _____ has discussed this procedure; the nature, purpose, complications, significance of risk, alternative methods and prognosis.

**Anesthesia Consent**

I understand and accept the anesthesia treatment plan for the above named patient, including the risks, benefits and alternatives available.

Signature: _____ Date: _____

Relationship: _____

**Pathology Consent**

I understand that Pediatric Care Specialists may send out any pathology (tissue samples) surgically removed for biopsy along with any insurance/medical information pertaining to the above procedure. I am aware that I may receive a bill from either Conemaugh Memorial Hospital or Somerset Hospital and/or their affiliates for this service, separate from those of Pediatric Care Specialists.

Signature: _____ Date: _____

I understand that Pediatric Care Specialists may bill me for any procedure in which my insurance does not cover, according to insurance guidelines.

**I understand by my signature below, I consent to the procedure(s) listed above.**

Signature: _____ Date: _____

Relationship: _____

Witness: _____ Date: _____