Gentle Circumcision®

Patient Information

Date:_____

Patient:_____ Date of Birth:_____ Age:_____

Address

Street Number:_____ City/State/Zip:_____

Home Phone:_____ Other Phone:_____

Email Address: _____

Emergency Contact Person:_____ Phone Number:_____

Referred by: _____Phone Number:_____

Medical History

- HIV/ AIDS ☐
- STD'S ☐
- Current Medications:_____

Date:_____ **Patient Signature:**_____

Gentle Circumcision®

CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Dr. Jerome S. Pittman and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him or her to perform the following (IN MEDICAL TERMS KNOWN AS):

(IN COMMON TERMS KNOWN AS): **circumcision**

and/or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as a considered medically advisable to remedy conditions discovered during the above procedure.

- **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding of the more common risks and complications of the treatment or procedure. These risks include the risk of bleeding, infection and pain. Rare complications include allergic reactions to anesthesia medications and death.
- **SPECIFIC RISKS AND COMPLICATIONS.** I am satisfied with my understanding of specific risks of this procedure or treatment including (Physician to describe specific risks where applicable).
- **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.
- **SECOND OPINION (if applicable).** I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.
- **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.
- **OTHER SERVICES.** I consent to the performance of pathology services as needed and I further authorize the disposal of any severed tissue. In accordance with customary hospital medical facility practice.
- **PHOTOGRAPHY.** I consent to the photography of the treatment or procedure for educational or diagnostic use.
- **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.
- **OTHER QUESTIONS.** I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.
- **FOLLOW-UP APPOINTMENT:** I understand that it is mandatory to bring the patient back for a one week follow-up appointment, which is included in the cost of the procedure.
- **HIPAA COMPLIANCE:** HIPAA stands for the American Health Insurance Portability and Accountability Act of 1996. They are a set of rules to be followed by doctors, hospitals and other health care providers. HIPAA took effect on April 14, 2006. HIPAA helps ensure that all medical records, medical billing, and patient accounts meet certain consistent standards with regard to documentation, handling and privacy.

My signature below confirms that I have read and received a copy of this form. Additionally, I have been given the required Notice of Privacy Practices documents in compliance with HIPAA.

DATE:_____ **TIME:**_____ **AM/PM**

PRINT PATIENT NAME:_____

SIGNATURE:_____
(PATIENT, PARENT OR LEGAL GUARDIAN)

PHYSICIAN:_____

WITNESS:_____