Prostiva® Therapy Consent Form

Patient Name _____

Date _____

I here by authorize Dr. _____ and the Facility/Surgery Center, and/or such assistants as may be selected by him or her to perform upon _____ the Prostiva RF Therapy.

1. It has been explained to me that during the course of the Prostiva procedure, unforeseen conditions may be revealed that necessitates an extension of the procedure or different procedures than that set forth in Paragraph One. I therefore authorize and request that my doctor and/or his associates or assistants, as he may designate, perform such procedures as are necessary and desirable in the exercise of their professional judgement.
2. The nature and purpose of the Prostiva procedure, possibly alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me.
3. I have also been informed that in the performance of any medical procedure that there are risks such as severe loss of blood, infection, etc. I am aware that the practice of medicine and the performance of medical procedures are not exact science. I acknowledge that no guarantees have been made to me regarding the result of the procedure.
4. I consent to the photography or videotaping of the procedure to be performed, including appropriate portions of my body, for medical, scientific or educational purposes.
5. I am aware that the practice of medicine is not an exact science, and I acknowledge that neither the facility/surgery center nor the physicians have made any guarantees as to the results that may be obtained or the consequences that may follow the procedure. I acknowledge that no contractual relationship, either expressed or implied, exists between the faculty and myself in connection with any medical services or treatment that may be rendered to me by the facility except the usual prevailing facility services and care under the direction and instructions of my physicians.
6. I understand that I am required to have a competent companion accompany me to the facility and be available during and after the procedure, and that I will be discharged to that person's custody and must rely upon him or her for my return home.
7. Certain costs for medical equipment, disposables (gauze, syringes, sterile supplies, etc.) or services may arise during the performance of the procedure which may be billed collectively as a "facility fee" to my insurance company.
8. I grant the right to release my files for future clinical research.

I certify that I have read this form or have had it read to me and my questions have been adequately answered and that I fully understand its contents.

_____

Patient Signature Witness

_____

Witness (2nd witness only required if patient signature is "X") Physician

UROLOGIX®