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Informed consent for TONSILLECTOMY with or without ADENOIDECTOMY

OVERALL VIEW OF THE TONSIL AND ADENOID ISSUE:

Waldeyer's Ring is the name given to collections of lymphoid tissue that surround the back of the nose and the mouth at their respective entrances into the throat. The tonsils and adenoids are PART of that circle. The Ring is ideally located to guard the respiratory system from invasion by bacteria and viruses by capturing them and producing protective antibodies against them. In most people, **tonsils** are easily seen on the sides of the throat behind and above the tongue, but the **adenoids**, because of their position behind the nose and above the soft palate, can only be seen using a mirror or a special telescope passed through the nose. The "job" of the tonsils and adenoids seems to be to attract and give infectious organisms a temporary place to grow and prosper while they prepare antibodies against those very same guests. In the IDEAL SITUATION, these antibodies eventually cause "bad bugs" to disappear from the throat. If those bugs should ever reappear, the antibodies will still be around to protect the throat, lungs and the rest of the body from infection.

This protective function is most important **early** in an individual's life. BUT with the passage of time, this role gets **less and less important,** because the same antibodies that the tonsils and adenoids produce are also produced by other parts of Waldeyer's Ring and by other parts of the lymphoid system which are located in remote parts of the body. Thus, at any age, **THE TONSILS AND ADENOIDS ARE COMPLETELY EXPENDABLE,** and for all practical purposes, the body will not, in any way, be worse off for their having been removed or having stopped functioning.

On the other hand, TONSILS AND ADENOIDS CAN BECOME LIABILITIES! These organs can turn into **RESEVOIRS** of pathogenic (disease producing) organisms, and **rather than being protective,** they then actually become SOURCES of **recurrent infection.** Furthermore, either or both of these organs can be so big as to cause significant **obstructive symptoms**. Although big tonsils and adenoids are usually those that have been recurrently infected, even healthy ones can be too large and obstructive.

Tonsils and adenoids are not ALWAYS removed at the same time. In children, it IS pretty standard to remove the adenoids any time that a tonsillectomy is being done, but this is not necessarily the case in adults. As often as not, the adenoids are removed from children as a separate procedure. It is rare for an adult to need an adenoidectomy, but occasionally a grown person is seen in whom the adenoids have not shrunk with advancing age. At any age, tonsils are not usually removed unless there are specific indications to do so. It DOES occasionally happen that a patient who is having adenoidectomy as an independent procedure at one point in time will develop new symptoms that indicate the need for tonsil removal at some time in the future.

SOME OF THE MORE COMMON INDICATIONS FOR TONSILLECTOMY:

1. Recurrent bouts of Streptococcal infection, tonsillitis and/or pharyngitis.

2. Streptococcal carrier state.

3. Recurrent sore throats and/or tonsillitis due to bacteria other than Streptococcus. (Everyone, it seems, knows of the association between Streptococcus and tonsillitis. Not everyone appreciates the fact that ALL

SORTS of pathogenic bacteria, not just "strep", can cause tonsillitis and non-specific sore throats (pharyngitis) as well! Clinical studies show that people with recurrent tonsillitis or pharyngitis continually harbor "bad" bugs in their throats even when they are well. These bad bugs disappear when the tonsils are removed. So do the recurrent bouts of pharyngitis and tonsillitis!

4. Peri-tonsillar abscess.

5. Unwanted change in speech quality -as if the patient has a "hot potato" in the back of his throat.

6. Interference with comfortable swallowing with or without unexplainable gagging and/or vomiting.

7. Drooling of otherwise unknown cause.

8. Intolerance and/or allergic reactions to antibiotics, and other agents used for alleviation of the above.

9. Tonsillar DEBRIS. These are foul smelling white spots that recurrently collect in the deep crypts of an otherwise healthy tonsil's surface (as opposed to the exudative white spots that accompany a flagrant acute inflammation of the tonsils). These occasionally become symptomatic enough to require surgery.

10. **SNORING and/or OBSTRUCTIVE SLEEP APNEA**. Nowadays, this has become one of the more common indications for T & A in children. Snorers may suffer intense embarrassment and loss of self-esteem and may greatly annoy those who share the night with them, but this is not necessarily a health problem. With a more intense degree of obstruction **Obstructive Sleep Apnea** develops, and if severe enough, this CAN be a threat to one's health and even to life! Treatment of this condition is a MEDICAL NECESSITY. **In children, it is almost a given that all severe SNORERS HAVE OBSTRUCTIVE SLEEP APNEA! And this can cause stunted growth, bed-wetting, daytime somnolence, loss of pep and behavior and learning problems.** In adults, other anatomical issues besides tonsil and adenoid hypertrophy may be responsible for the obstruction. However, **in children, sleep obstructive problems are caused almost exclusively by large tonsils and/or adenoids**. It is for this reason that their surgical removal is often recommended for a child who is snoring, even though there may be no other indication to remove them, and this aggressive approach **cures the obstructive problem almost 100% of the time along with significant improvement in quality of life issues. Of course, although rare, it is always possible that other anatomic factors may be present that will result in a continuation of the snoring and apnea problem, but these are difficult to identify until the tonsils are removed.** Although a **Polysomnogram or Sleep Study (PSGM**) is a mandatory diagnostic tool for adults, it is RARELY helpful or necessary for defining the problem in children.

SOME OF THE MORE COMMON INDICATIONS FOR ADENOIDECTOMY:

1. Nasal obstruction with or without perpetual mouth breathing.

2. Hypo-nasal speech quality.

3. Drying out and erosion of front teeth and dental occlusion problems.

4. So-called "adenoid facies."

5. Persistent snotty nose with or without frequent "colds" and with or without true sinus infections

6. Serous **OTITIS MEDIA** with or without recurrent bouts of acute otitis media and with or without prolonged periods of decreased hearing, and with or without delay of language and/or intellectual development.

7. Intolerance and/or allergic reactions to antibiotics, and other agents used for alleviation of the above.

EVALUATION AND PREPARATION OF A PATIENT FOR SURGERY:

1. The **routine ENT exam looks at** all the pertinent structures and functions of the head and neck for disease processes of all sorts.

2. **Fiberoptic Endoscopy** using topical anesthetic in the nose and a flexible telescope provides a direct and painless look at structures in the throat that are otherwise difficult to examine. It is not ALWAYS necessary, but when it is, we are able to view the adenoids, the naso-pharynx, the back of the nose, and the Eustachian tubes as well as the deeper parts of the throat and the larynx in both their static and dynamic states.

3. A **General Physical Exam and Overall Medical History:** Systemic health problems can affect the way a patient responds to anesthesia and surgery. Adult surgical patients are required to have a written pre-operative **medical clearance** by their primary care physician which will go into the hospital chart. We will provide you with a special form to be filled out.

We assume that children are under the constant surveillance of their primary physicians, so we merely ask that their parents be certain to speak directly to the child's physician about surgery and to ask that doctor to get in touch with us if he/she feels there are special issues that need to be discussed. This call is not necessary if everything is considered "routine."

4**.** It is important that you discuss the patient's ENTIRE **MEDICATION SCHEDULE AND DRUG ALLERGY LIST** with us before you go to surgery. We especially need to know if there are **ALLERGIES or ANY OTHER TYPES OF INTOLERANCES** to Valium? Morphine? Codeine? Or other pain killers? Penicillin? Or other antibiotics? Etc., etc.

5 Although the way we do our tonsil surgery is usually bloodless, it is important that **drugs which interfere with the ability of blood to clot are avoided.** This includes Aspirin, Ibuprofen, and other Non-Steroidal Anti-Inflammatory Drugs (NSAID's) as well as Coumadin, heparin, Persantine and other anticoagulants. Ideally, all of these medications should be avoided for 2 weeks before and 2 weeks after any kind of surgical treatment. These drugs must be discontinued under the **close supervision of the doctor who originally prescribed them!** Do not do this on your own.

6. Certain drugs used to treat **depression** called **MONOAMINE OXIDASE (MAO) INHIBITORS** are incompatible with some of the agents we use. **If ANY drugs of this class, are being taken, please have them discontinued at least two weeks before surgery, and do this UNDER THE STRICT CONTROL OF THE PRESCRIBING DOCTOR.**

7. If **PROPHYLACTIC ANTIBIOTICS** are needed before surgery for **cardiac abnormalities** such as Mitral Valve Prolapse, cardiac pacemaker, valve replacements, rheumatic fever, or **metallic implants** such as teeth or joint replacements, screws, bolts, plates, wires or other orthopedic devices are needed, you must be sure to follow the prophylactic antibiotic regimen that your **MEDICAL DOCTOR, CARDIOLOGIST, DENTIST OR ORTHOPOD should be prescribing for you.**

8. Oral **HERPES SIMPLEX eruptions,** recurrent **aphthous ulcers** or other **viral sores** of the mouth, lips and throat may be aggravated on a temporary or permanent basis by **this** or **any** kind of surgery. If there is a tendency toward such outbreaks, let us know so that we can prescribe an anti-viral medication prophylactically.

9. **Pre-admission** blood tests, urinalysis and possibly an EKG and chest X-ray may need to be done**. Call the hospital or surgery center** to schedule**.** Then, please, **CALL OUR OFFICE** to confirm the results of these tests as soon as they are reported to us.

10**.** A **CONSULTATION WITH AN ANESTHESIOLOGIST from may be arranged. This is an opportunity for you to discuss special conditions, needs and preferences, and have all your questions regarding anesthesia answered. You should arrange to have this done at the SAME TIME AND PLACE as the PAT blood tests are being done, and should be done as soon as practical.**.

11. Except in a few unusual circumstances, it is NOT necessary to make ANY provisions for BLOOD TRANSFUSION.

12. **If you expect your insurance company or HMO to pay for your surgery, make sure that we have obtained proper PRE-CERTIFICATION, and** that **appropriate** CONFIRMATION NUMBERS, ETC**., are on record.** (Note that insurance companies are often CAPRICIOUS, and that even though approvals might have been granted, it is still possible for them to deny payment on your behalf after the treatment is completed.)

SURGERY AND POST-OP ISSUES:

A. We do our TONSIL SURGERY in the OPERATING ROOM at hospital or surgery center. We will use a variety of traditional and specialized surgical instruments, lasers, cauteries, harmonic scalpels, and/or chemicals etc, as best suit our patients' specific needs. GENERAL ANESTHESIA will be administered under the direction of the anesthesiologist assigned to the case. (IF YOU HAVE A SPECIFIC CHOICE OF WHO YOU WOULD LIKE THAT DOCTOR TO BE, YOU MAY INDICATE YOUR PREFERENCE AT THE TIME OF YOUR ANESTHESIA CONSULTATION.) Patients need to have had all their outside medical clearances, anesthesia consults and lab tests done in advance of surgery.

B**. NOTHING should be eaten or drunk on the morning of surgery. Stomachs should be empty for 8 hours before the expected time of surgery with the exception of only the tiniest amount of water needed to take required medications. Admission will be a few hours before surgery.**

C. After surgery you will be given a comprehensive **POST-OPERATIVE INSTRUCTION SHEET** and **PRESCRIPTIONS** for various medicines. We ask that a responsible adult be available to check on the patient through the first post-op night to make sure there are no complications. Be certain that the patient is not allergic to anything that we prescribe. Keep in mind that all drugs can have **side effects.** They can make you sleepy, upset your stomach and/or affect your bowel habits in either direction!

D**.** If the operation is uncomplicated, it is likely that the patient will be discharged from the hospital **late on the day of surgery**. If necessary, the patient can be kept over night. PARENTS SHOULD BE PREPARED TO STAY WITH THEIR CHILDREN IF OVERNIGHT STAY IS NECESSARY.

E. If EXTENSIVE **nose or sinus surgery,** is being done at the same time as tonsillectomy, it is SOMETIMES our **ROUTINE** to admit the patient to the **special care unit** for **overnight monitoring** of breathing to make sure that sleep apnea is not a problem.

F. **If there is an overnight stay, for any reason, IT IS MANDATORY THAT YOU CALL YOUR INSURANCE COMPANY IN THE MORNING. INFORM THEM of the extension and tell them to GET IN TOUCH WITH OUR OFFICE STAFF LATER IN THE DAY for details.**

G. Post-operative pain will be considerable.

H. Nausea is frequently a problem for the first few hours after surgery. It rarely lasts overnight. Medications will be available.

I. AFTER DISCHARGE, patients will have liquid medicines that they can take by mouth on a "LITTLE BY LITTLE" basis mimicking the PCA administration technique they followed in the hospital.

J. Be certain that the patient is not allergic to anything that we prescribe. Keep in mind that all drugs can have **side effects.**

K. A **responsible adult** MUST be available to check on the patient through the first post-op night to make sure there are no complications.

L. Patients are given anesthetics and various drugs during hospitalization that will cause sleepiness and interference with vision and clear thinking. These effects can last as long as 48 hours after surgery. Then when pain medication is taken AFTERWARDS, there will be a direct trade off between grogginess and pain relief. It is imperative that patients not **DRIVE nor should** they do anything that requires **GOOD JUDGMENT AND GOOD VISION until they are in full control of their faculties.**

M. **Post op patients do not have to stay in bed, and don't even have to stay in the house. But post-operative pain after tonsil surgery IS significant.** The younger the child, the better pain seems to be tolerated. For children, the worst of the post-op pain lasts between 2 and 5 days. Even if not feeling perfect, kids can go back to school fairly soon after surgery. Returning to normal routines seems to be therapeutic and should be encouraged-within reason!

For ADULTS, It may be 7 to 10 days before there is a desire to resume normal activities.

N. The ability to eat and drink after tonsillectomy is usually difficult. It is not necessary for the post-op patient to eat food per se, but it is necessary to maintain an adequate liquid intake and even that can be a problem. Nevertheless, there are only rare instances in which a patient had to go to the Emergency room for IV's, and/or had to be admitted to the hospital because of an inability to maintain proper hydration or pain control.

O. We doctors do not know for sure whether **restriction of physical activity** is REALLY necessary or not, but it is CUSTOMARY to advise CAUTION on this issue. A certain amount of moving around is definitely a good thing, but for **TWO WEEKS** POST-OPERATIVELY we have to go on record and tell the patients to limit themselves to relatively mild physical exertion and to avoid activities and or body positions that tend to raise the venous pressures in the face and head, i.e., weight lifting, doing sit-ups and bending over excessively, etc.

P. From a statistical point of view, except for the above, post-operative complications and troubles are extremely rare, and are almost unheard of after 2 weeks. Until then we suggest that patients either stay in Mercer county, or make sure, **ahead of time,** that if **traveling,** there is access to a facility which has doctors who have the wherewithal to handle things if the need for care should the need arise.

Q. SOMETIMES, DURING THE COURSE OF AN OPERATION, CONDITONS OR SITUATIONS MAY REVEAL THEMSELVES THAT BEFORE ANESTHESIA AND/OR SURGICAL EXPOSURE WERE NOT OBVIOUS. IF THE PATIENT IS A CONSENTING ADULT OF AGE GREATER THAN 18 YEARS, THERE IS NO ONE WHO IS LEGALLY ABLE TO GIVE INFORMED CONSENT TO THE SURGEON TO TAKE CARE OF SUCH ISSUES. IF THE PATIENT DESIRES THAT I EXERCISE MY BEST PROFESSIONAL JUDGMENT AND PROCEED TO HANDLE

SUCH ITEMS, HE/SHE MUST GIVE ME THAT PERMISSION "CARTE BLANCHE" WHILE IT IS STILL APPROPRIATELY LEGAL FOR HIM/HER TO DO SO AND SIGN AT THE APPROPIATE SITE ON THE HOSPITAL'S OPERATION PERMIT. IN THE CASE OF A MINOR, I WILL BE ABLE TO DISCUSS THE ISSUE AND GET LEGAL CONSENT FOR SUCH EVENTUALITIES FROM THE APPROPRIATE GUARDIAN.

THE POSSIBLE DOWN SIDE TO TONSIL (and ADENOID) SURGERY:

No medical or surgical treatment –or any activity for that matter -is entirely without risk. Tonsil and adenoid surgery is very common. It is technically easy to do, and because it is usually done on otherwise healthy people, there are very few bad outcomes. The same may be said for the anesthesia. But deaths, central nervous system catastrophes, cardiac and lung problems and **a whole host of other bad outcomes HAVE been reported**. As with any surgery, doctors and patients alike **must be prepared for absolutely anything**.

The list of possible complications and/or bad outcomes that are common to any and all operations is miles long. It is neither practical nor productive to mention them all here. But some things that are specific to tonsil and/or adenoid surgery ARE worth mentioning. However, except for the delayed bleeding issues which are discussed below, all other complications taken collectively are **very rare**.

1. Thanks to modern anesthesia and surgical techniques, ACUTE BLEEDING right after surgery is rare. If it should occurs it might be manageable at the bedside, but could require a trip back to the operating room.

2. **DELAYED BLEEDING** is that which occurs sometime AFTER the initial post-op period, most notably between the 4^{th} and 12^{th} days after surgery. I once saw a bleeding patient 18 days post-op! The occurrence rate is **5%** of tonsillectomy patients! **Thus it IS a statistic to be respected. This usually occurs due to slough & poor wound care**.. However, if it does occur, it is NOT likely to be serious. In many cases it may even resolve by itself, quickly, and without need for special treatment. In adults, if necessary, it can usually be handled on an ambulatory basis in the office or Emergency Room. General anesthesia may be necessary especially for younger patients. This is the reason we tell our patients to stay around Mercer county for two weeks, or, if they are going to travel, to be sure that they are in a place where they know they can DEFINITELY get competent care if it should be needed.

3. When a thoughtful selection of patients is done, the operation almost always accomplishes all that it is expected to do. However, NOTHING IN MEDICINE IS ABSOLUTE. Tonsillitis is not likely to happen, Strep infections will very rarely recur, BUT ordinary colds and viral pharyngitis will, of course, occur with the same frequency that everyone else experiences. There is always a possibility that the small amount of adenoid tissue that is invariably left behind can continue to get infected, and that ear infections and sinus infections can continue to be a problem.

4. Although we are careful to look for certain signs that might indicate a potential for post-operative **swallowing or voice and speech difficulties**, it is possible that in spite of our best efforts, they could develop as a result of surgery.

5. Scar bands, even to the extent of needing difficult reconstructive surgery, have been reported following T & A surgery. These cases are exceedingly rare.

6. **There is no guarantee that snoring and obstructive sleep apnea will be eliminated –especially in adults. Keep in mind that there may be other anatomic factors that may need to be contended with after the tonsils and adenoids are gone.**

7. There will always be some patients who complain of non-specific lingering pain, numbness, tingling, dryness, wetness, or vague discomfort in the throat, and changes to swallowing and voice and speech even when everything seems to have gone well.

8. Singers, actors, lecturers, preachers, and other voice professionals, musicians who play wind instruments, etc., must be alert to the fact that there could be a change in their performance ability after the surgery and the **endo-tracheal tube anesthesia**. Although we are unaware that it has happened in T & A patients, it is theoretically possible that someone, who speaks French, Arabic, Hebrew, Yiddish, German, or other languages which roll R's and/or have sounds which rely on vibration of the palate, might NOT be able to pronounce these particular sounds after surgery.

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9. An occasional patient will develop pneumonia following surgery. Nowadays, that is usually easily treated.

10. Some patients who have adenoidectomy will get significant stiffness of their neck muscles post-operatively. It is **remotely** possible that this could be permanent.

11. PAIN, SWALLOWING PROBLEMS and CONVALESCENCE issues can be considerable. Sometimes patients are re-admitted to a hospital for supportive care, especially if DEHYDRATION is an issue.

12. MEDICATIONS are going to be necessary post-operatively. Drug reactions and interactions do occur.

SO, DOCTOR, HOW DO I DECIDE WHETHER THIS SURGERY IS THE RIGHT THING TO DO?

I have given you a lot of information. It takes a lot of work and commitment to make the decision to have surgery, to prepare for it, to go through with it, and to get over it. The thought of a lot of pain and possible complications is scary. This surgery is **ELECTIVE**. It is NOT mandatory. You may have heard people say, "They don't do T & A's anymore," or that people "grow out of it". These statements are not necessarily true. There ARE antibiotics that take care of infections, and as far as obstructive symptoms are concerned, there IS a **NATURAL INVOLUTION and SHRINKAGE IN SIZE** of these tissues that takes place with the passage of time. It IS possible that, at least for children, trouble can resolve itself with advancing age. A sick teenager or adult can't necessarily depend on that. I have operated on people in their 40's still waiting for these tissues to shrink on their own!

Also, keep in mind that the bugs that cause these infections are developing resistance at an alarming rate to most of our safe and convenient antibiotics. Furthermore, there are **no crystal balls** that will foretell WHEN**, if ever**, the natural resolution with aging is going to take place. Nor can one predict whether the next infection, or any other one coming down the road, will, itself, result in some disaster, or cause a significant complication, nor whether a drug reaction to the next antibiotic is going to result in some serious event. Nor can someone else foretell the collective impact that these illnesses have on you and your family. Degrees of impact vary from one family unit to the next depending on the frequency and severity of individual episodes of illness, the family members' personal tolerance for adversity, their financial status, their professional or job situations, other social factors and their willingness to accept risk.

SO, the INDICATIONS FOR SURGERY COME DOWN TO THE FOLLOWING:

(A) When it becomes clear to you that antibiotics, decongestants, antihistamines, allergy treatments, dietary management, vitamins, holistic therapies, moving to a different climate, and the passage of time, etc. are not getting the job done to anyone's satisfaction.

(B) When the realization comes that your and/or your child's **QUALITY OF LIFE** is not what it could or should be.

(C) When you begin to be concerned about what the infection can do to you, if it is not treated, you would realize that the hazards of not doing it entail the spread of the infection to the sinuses, ears, lungs, abdomen & even the heart.

(D) When you recognize that being sick is NOT A GOOD THING and that the next "attack" could have serious consequences.

(E) When you recognize that ON MANY LEVELS repeated courses of antibiotics and other medicines are not a good thing.

(F) When there is a willingness and courage to accept some pain, a few minor post-operative restrictions and the rare though possibly serious complications of surgery in exchange for what will most likely, though not guaranteed, be a DRAMATIC AND RAPID end to the problems at hand.

(G) When you have simply decided that **ENOUGH IS ENOUGH**, and you want an IMMEDIATE AND ALMOST 100% PREDICTABLE END to the **unpardonable and unnecessary** condition that brought you to our office in the first place to see if anything could be done to improve your/your loved one's life and health.

(H) When you realize that snoring and or obstructive sleep apnea is interfering too much with a good life and the pursuit of happiness.

(I) **If you need confirmation that surgery at this time is the best course of action, do not hesitate to seek a SECOND OPINION. If you like, you can seek an appropriate doctor on your own, or I could help you with a referral to a doctor whose opinion I feel would be worth while.**

PERSONAL CERTIFICATION AND CONSENT FOR TONSILECTOMY WITH OR WITHOUT ADENOIDECTOMY

A. My **signature** below attests to the fact that I recognize that each decision one makes in life is a balancing of good against bad, **that there is no such thing as "the perfect operation,"** that surgeons do not always get perfect results, and that patients may not always be satisfied even when a good anatomical and functional result seems to have been achieved.

B. I attest that I have been fully **informed** about the rationale, risks, limitations, methodology, unpredictable factors and **alternative treatment** methods for the surgery that I have chosen to have; that I have carefully read and fully understand this **ENTIRE TEN PAGE DOCUMENT.** That I have not withheld any facts or information that might indicate a contra-indication to surgery or a need for any special considerations; that I have been told to confer with an anesthesiologist at the hospital so that I might better understand the anesthesia that is going to be used and the medications that may be used and their specific risks; that I have considered the ALTERNATIVES to surgery; that I have been offered the opportunity to obtain **other opinions** regarding the appropriateness of the recommended surgery; that I have been offered the opportunity to have my spouse and/or significant others, and/or family members and/or friends present during key discussions.

C. I acknowledge that this consent and the entire extensive document is applicable not only to surgery and anesthesia and hospitalization in a generic sense, but also to the specific performance of Tonsillectomy with

or without Adenoidectomy, and that if other procedures are performed concomitantly, additional and separate informed consents will be given.

D. I understand that in addition to the potential dangers and risks previously discussed in this handout, **the list of possible undesirable developments and complications** also includes, **but is not necessarily limited to, the following:** burning feelings; persistent pains; feelings of a lump, or of dryness, or of too much mucus and/or saliva in the throat or nose or neck; changes in the quality of voice and/or speech; difficulty with swallowing; alterations in taste, BLEEDING which could occur early on or delayed as long as two weeks or more after surgery, the need for blood transfusion and any or all of its attendant risks; anything and everything inherent in just being in a hospital and/or having any kind of operation in any place; unexpected and/or expected reactions to medications or to the surgical technique used. I understand that surgery may not correct all problems satisfactorily, and that the condition for which I am being operated upon could even be made worse. I appreciate that although the doctors involved with my case have tried to cover all bases in their effort to eliminate or at least MINIMIZE the occurrence of untoward events, there are some things that just can't be foreseen, and thus, undesirable outcomes can result despite best efforts to avoid them. I further understand that although complications are rare, they DO occur, and that it is possible that any of them could happen to my child or me.

E. IF I AM A MAJOR IN THE EYES OF THE LAW, ONCE I HAVE BEEN PRE-MEDICATED, NEITHER MYSELF NOR ANYONE ELSE, NO MATTER HOW CLOSELY RELATED TO ME- UNLESS THEY ARE LEGALLY DESIGNATED BY A SPECIFIC REGISTERED DOCUMENT – IS ABLE TO GIVE CONSENT TO ANY OF THE DOCTORS INVOLVED IN MY CARE. SINCE I RECOGNIZE THAT THINGS COME UP DURING THE COURSE OF MEDICAL/SURGICAL TREATMENT WHICH CAN NOT, OR HAVE NOT BEEN PREVIOUSLY ANTICIPATED I HEREBY BESTOW FULL AUTHORITY TO DR. _____ TO USE HIS BEST JUDGMENT ACTING IN MY BEHALF TO PERFORM HIMSELF OR DIRECT OTHER PHYSICIANS TO PERFORM IN MY BEHALF THOSE MANEUVERS OR PROCEDURES OR MEDICATION ADMINISTRATIONS WHICH ARE DEEMED TO BE IN MY BEST INTERESTS. I also certify that I will accept monetary responsibility for those actions. This document shall serve as informed consent for my primary treatment in the hospital or other venues, and that many of its provisions may be pertinent for subsequent related treatments and procedures as well, until such time that in the eyes of the law, I am able to make my own decisions and direct my own care..

F. Regarding medical insurance, I understand the implications and limitations of the terms "covered service" and "non-covered service", that pre-certification from my 3rd party payor does not necessarily mean that it will actually pay for my treatment, and that if my doctors acting on my behalf are required to render extensive written documentation beyond the usual, I will compensate them for their efforts.

G. I understand that my doctor has arrangements with some insurance companies to provide certain approved services at a pre-negotiated price, and that if such an arrangement applies to the services provided to me, I will be covered to the extent that my contract with my insurer provides, and that if there are any deductibles and or co-pays that I am responsible for, I will pay them as soon as it is clear what those charges are, or at the latest, within the **same billing period of the time that my carrier pays my doctor.**

H. I understand that there are no guarantees as to exactly what the result of the contemplated surgery will be, and that I am assuming this financial responsibility regardless of how good or bad the outcome of the surgery turns out.

I. I understand that the stated fee is to cover the cost of the performance of the intended procedure(s) and a global period of **ROUTINE** post operative care as defined by my insurance carrier or three weeks whichever is longer, BUT that additional charges may be made for future endoscopies and or other special procedures

that are not considered part of the usual and customary post-op care. I also agree to assume responsibility for additional fees which may be charged for other related or non-related surgeries or treatments that might become necessary either during or sometime after the defined post-operative period.

I understand that potential risks associated with any surgery could include, among other things, broken teeth, pain, bleeding, infection, need for more surgery, need for more medications, loss of airway and suffocation, stroke and other injury to brain, heart attack, pulmonary embolus (blood clots in lungs and other body parts) and death.

_____	_____	_____
Signature of patient (or parent if a minor)	date	print name and relationship of signer
_____	_____	_____
signature of witness	date	print name and relationship of witness

Please sign one of these forms and return it to us. Keep another copy along with the rest of this document in your permanent files. Thank you.

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