

**Consent Form for Anesthesia**

**Palm Beach Center for Reproductive Medicine/ Palmetto Fertility Center of South Florida**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Indications and extent of treatment:** I understand that this consent authorizes the administration of anesthetics for the relief of pain and to induce a state of conscious sedation during the surgical procedure(s) which I have consented to undergo. Conscious sedation is a technique also known as “twilight sleep” or light sedation (Level II).

I understand the anesthesia will be administered by a licensed Anesthesiologist who is a member of South Florida Anesthesia Associates, P.A. The Anesthesiologist is an independent contractor and not an employee of Palm Beach Center for Reproductive Medicine/ Palmetto Fertility Center of South Florida.

I understand that a choice of anesthesia provider exists (i.e., a certified registered nurse anesthetist, a physician assistant, another trained physician, or a registered nurse under physician supervision) as set forth in rule 64B8-30.012(2)(b)6., Florida Administrative Code, and I may choose these options rather than have a physician anesthesiologist administer my care.

**Risks of this procedure:** I understand that anesthesia involves potential risks inclusive of, and in addition to the risks of the surgical procedure(s). These risks may include, but are not limited to, injury to teeth, damage to vocal cords, respiratory problems, minor pain and discomfort, loss of sensation, or headaches. I may experience pain or inflammation at the site of the intravenous injection or insertion site of the IV. I also understand that the administration of anesthesia is not an exact science, and very infrequently, death, paralysis, or other complications may occur.

**I understand that this anesthesia will be administered in a doctor’s office regulated pursuant to the rules of the Board of Medicine as set forth in Rule Chapter 64B, F.A.C.**

**Financial:** I understand that insurance coverage for any or all of the above treatment may not be available and that I will be personally responsible for the expenses of this treatment. The expenses may consist of medication charges and physician professional fees.

I acknowledge that the physician has explained to me and I understand the following:

1. The nature and purpose of the procedure in layman’s terms
2. Significant risks of this procedure.
3. Alternatives to the procedure.

*I have had the opportunity to ask questions and to clarify the nature of the procedure, the risks, and alternatives. I certify that I have read and fully understand and consent to the administration (or induction) of anesthesia, and that the risks and alternatives to the procedure were fully explained to me.*

Patient’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness’s Signature \_\_\_\_\_ Date \_\_\_\_\_