INFORMED CONSENT FOR SURGICAL PROCEDURE OR TREATMENT

I hereby request, authorize, and give my consent to Christopher J. Kovanda, M.D. to perform the following surgical procedure or treatment:

______________________________________________________________________

The complications and limitations of the above-mentioned procedure have been explained to me in detail and in terms I can understand. I am aware that the possibility of unforeseen complications also exists. I have been given the opportunity to question each point listed and have been informed of alternative treatment options, including the option of no treatment.

I understand that any clinical photographs or x-rays taken of me are the property of the physician and may be used for medical education.

In the event that revisional or secondary procedures are required, I understand that I will be responsible for both facility and anesthesia fees.

______________________________________________________________________

Patient Signature _______________________________ Witness _______________________________