Stephen A. Hickner, M.D.,LLC

CONSENT FOR OFFICE PROCEDURE

DATE_______________ PATIENT_____________________________________

I, ____, authorize the performance upon

____, of the following procedure:

____ for the diagnosis of:_________________

under the direction of Dr. Stephen Hickner

for the purpose of:____.

I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedure have been explained to me as well as the possible risks and benefits of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. No guarantee or assurance has been given by anyone as to the results that may be obtained from this procedure.

_______________________________________ _______________________________________

Patient Signature Witness

_______________________________________ _______________________________________

Age of Person Consenting Relationship to Patient

____

Signature of Informant