



Consent for Performance of In-Office Procedure:

I hereby authorize Lindsay Barton, CNP and whomsoever she/he may designate as her/his assistant to perform upon Daedra Mariette the following in-office procedure(s): Removal of ingrown toenail

In addition, I understand my nurse practitioner may designate specific qualified tasks to individuals who are credentialed members of the medical staff. The names of these individuals will be recorded in the in-office procedure record or plan section of the patient's chart.

She/He is further authorized to perform such additional in-office procedures as she/he may consider therapeutically necessary on the basis of findings during the course of said in-office procedure.

The nature and purpose of the procedure, possible alternative methods of treatment, the prognosis if no treatment is received, the risks involved, the benefits sought and the possibility of complications, the likelihood of achieving my healthcare goals, and any potential issues that might occur during recuperation have been fully explained to me. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

I authorize and direct the above-named nurse practitioner and her/his associates as well as assistants or persons she/he may designate and supervise, to request/provide such additional services as they deem reasonable and necessary, including, but not limited to: the administration of a local anesthetic or the performance of pathological procedures. The type of local anesthetic planned for my procedure and condition has been explained to me. I further understand that my condition may necessitate a change in local anesthetic or referral to another facility with a higher level of care. As with any medical procedure, carries certain risks, which include, but are not limited to: injury, adverse drug reaction, infection, bleeding.

I consent to the disposal, by Auburn University Montgomery Warhawk Health Services and/or its contracted pathologist, of tissues, parts or members which may be removed as necessary part of my care.

I consent to the taking and publication of any photographs or videotape recordings taken in the course of the in-office procedure for the purpose of advancement of medical knowledge, and I understand that the same are the property of the treating nurse practitioner.

I also consent to the presence of observers, i.e., students of nursing, for the purpose of advancing medical techniques.

I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS CONSENT. I UNDERSTAND THE RISKS, BENEFITS, AND ALTERNATIVES INVOLVED IN THIS PROCEDURE. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

This consent has been explained to me and I understand its contents.

[Signature]
Witness

[Signature]
Signature of Patient/Responsible Party/Relationship

12/11/23
Date

1430
Time

Telephone Contact Information: 334-510-0593
Name of Responsible Party: Daedra Mariette
Contact Number: _____

I have discussed the procedure named above, including potential risks, benefits, and side effects of the patient's proposed plan of care, treatment, and services. I have discussed the likelihood of the patient achieving his/her goals and potential problems related to recuperation. The discussion included the side effects to the alternatives and the risks related to not receiving proposed care, treatment, and services. The patient/family understands and acknowledges that questions were answered to their satisfaction and requests to proceed.

Healthcare Professional Signature: [Signature] Date: 12/11/23 Time: _____