happy kids pediatrics

Procedure Authorization

Patients Name: _____ DOB: _____

I, _____ parent/ guardian of the minor _____ authorize Jose Francisco Carrazco, M.D., F.A.A.P. and any provider acting as an agent of Happy Kids Pediatrics P.C. to perform the following operations or procedures.

☐Circumcision ☐ Wart/ Lesion Removal☐Toenail Removal ☐ Ear Piercing☐ Frenectomy

RISK: This authorization is given with the understanding that any operation or procedure involves some risk and hazard; some of the ***significant risks are cardiac failure, respiratory failure, and undesired cosmetic results.*** More common risk of any procedure includes infection, bleeding, nerve injury, blood clots, allergic reactions, and pneumonia. These risks are serious and possibly fatal.

RESULTS NOT GUARANTEED: I understand that no guarantee or assurance has been made to the results of the procedure and that it may not cure the condition.

PARENTAL CONSENT: I have read and fully understand this consent form, I comprehend that I should not sign this form if all items or questions have not been fully explained or answered to my satisfaction or if I do not understand any of the terms or words contained in the consent form.

I understand that Ahcccs programs do not cover the above procedures and that I am fully liable for the cost of the service. If I do not pay for the cost of the service the bill may go into collections.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS AND OR HAZARD OF THE PROPOSED PROCEDURE OR ANY QUESTIONS CONCERNING THEM, ASK YOUR HEALTHCARE PROVIDER BEFORE SIGNING THIS FORM.

Parent/Guardian Signature _____Date_____

Providers Signature _____ Date _____