



Cardiosmart PLLC
Bayside Cardiac Care
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Location:

Location options: 216-16 Union Turnpike, Bayside; 266-19 Union Turnpike, Queens; 207-07 Hillside Avenue, Queens

NAME: _____

DOB: _____

MRN: _____

CONSENT FOR
INVASIVE/DIAGNOSTIC/THERAPEUTIC PROCEDURE

Permission: I hereby authorize Dr. _____ and his/her associates or assistants who are _____(MD, PA, NP, RN, MA) at Cardiosmart PLLC, Bayside Cardiac Care to perform the following procedure(s): (procedure to be written both in medical terminology and in terms that the patient can understand).

Explanation of procedure(s), risks, benefits and alternatives: Dr. _____ has fully explained to me the nature and purpose of the procedure(s) and also informed me of expected benefits and complications (from known causes), attendant discomforts and the risks that may arise, as well as possible alternative methods of diagnosis and/or treatment to the proposed procedure(s), including no treatment. I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

Understanding of this form: I confirm that I have read this form, fully understand its contents and that all blank spaces above have been completed prior to my signing. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s) described above.

Patient/Agent/Relative/Guardian* Signature Date

Print Name Relationship if other than patient

Interpreter, if required Signature Date

Print Name

Witness to signature Signature Date

Print Name

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Responsible Practitioner's Certification. I hereby certify that I have explained the nature, purpose, benefits, complications from, risk of, alternatives to (including no treatment and attendant risks), and the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I further certify that the "Permission" section of this form accurately identifies the proposed procedure.

Provider's Signature Date