MARK BROUDO, M.D. P.A.

1100 SW 57 AVENUE
SUITE 100
MIAMI, FL 33144

SPECIAL CONSENT TO OPERATION OR OTHER PROCEDURE

PATIENT:_____ **DATE:**_____

TIME:_____

1. I hereby authorize Dr. Mark Broudo to perform the following surgical procedure:

   _____

   For the purpose of:_____

   _____
2. The above doctor has personally explained the procedure listed in the Paragraph 1 to me, and I completely understand the nature and consequences of the procedure. The following points, among others, have been specifically made clear:
   a. There may be scars as a result of this surgery. Every effort will be made to conceal or to make them as inconspicuous as possible.
   b. There may be swelling which can persist for several weeks.
   c. There may be discoloration (black and blue marks) which can persist for several weeks.
   d. No guarantee has been made regarding the amount or percentage of improvement or the permanency of the results.
   e. At times fluid or blood may accumulate in the operative sites which may require aspiration or drainage.
   f. Infection is possible in any type of surgery.
3. I recognize that, during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set forth above. I therefore further authorize and request that the above named surgeon, his assistant, or his designees perform such procedures as are, in his professional judgement, necessary and desirable, including, but not limited to, procedures involving pathology and radiology. The authority granted under this Paragraph 3 shall extend to remedying conditions that are not known to the above doctors at the time the operation commences.
4. I consent to the administration of local anesthesia to be applied by or under the direction and supervision of the above doctor with the exception of:_____
5. I recognize that when general anesthesia is used it presents additional risks over which the above doctor has no control and I agree to discuss the risks of general anesthesia with the anesthesiologist before surgery is performed.
6. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure.
7. I consent to be photographed before, during and after the treatment; that these photographs shall be the property of the above doctor and may be published in scientific journals and/or shown for scientific reasons.
8. I agree to keep the doctor informed of any change of address so that they can notify me of any late findings, and I agree to cooperate with the above doctor in my care after surgery until completely discharged.
9. I am not known to be allergic to anything except:_____

I HAVE READ THE ABOVE CONSENT AND RECEIVED A COPY OF IT. I FULLY UNDERSTAND THE CONTENTS OF THE CONSENT AND AUTHORIZE AND REQUEST THE ABOVE DOCTOR TO PERFORM THIS SURGICAL PROCEDURE ON ME.

WITNESS:_____ **PATIENT:**_____