Kimberly Cockerham, MD, FACS
Oculofacial Plastic Surgery
Eyelid & Orbital Oncology
Thyroid Eye Disease
Neuro-Ophthalmology

Patient Name: ____ DOB: ______________

Surgical Procedure: ____
Right Eye Left Eye Both Eyes

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Right Eye Left Eye Both Eyes

In Office Procedure Consent Form

I, ____, consent to the medical/surgical procedures outlined below to be performed by Dr Kimberly Cockerham and staff, associates, or assistants to whom the physician(s) performing the procedure may assign designated responsibilities.

The proposed medical/surgical procedure is ____
for the diagnosis/treatment of ____.

I acknowledge that the procedure has been explained to me in terms that I understand. The explanation included:
• The nature and extent of the procedure to be performed.
• The most frequently occurring risks of the procedure involved, and those risks which are unlikely to occur but which may involve serious consequences, include but are not necessarily limited to the following:
____
____

- General risks which may include pain, scarring, bleeding and infection.
- The benefits of the procedure.
- The estimated period of incapacity or convalescence, if any.
- The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all.

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 concerning the results of this procedure.

I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures.

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I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures as required.

I understand that I may consult or could have consulted with another physician about this procedure.

I understand that I have the right to refuse any medical/surgical treatment recommended at any time prior to its performance.

I was given the opportunity to ask any questions I have regarding the procedure, and I have had those questions answered to my satisfaction.

I acknowledge that I have read (or had read to me) and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits and alternatives have been explained to my satisfaction.

I understand the potential risks, complications and side effects involved with the proposed procedure and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

Patient's Signature: ____ Date: ________________

Witness Signature: ____ Time: ________AM/PM

I verify that I have explained the information contained in this document to the patient or person giving consent. It is my opinion that the person granting consent has fully understood all subjects discussed.

Physician Signature: ____ Date: ____________