ACKNOWLEDGEMENT LETTER

Patient's Name: _____

This is to acknowledge that I have received and have read the informed consents at my convenience. They have been signed at CoZmedic Surgery Associates.

- I understand the complications and accept the risk as necessary to accomplish the desire result
- I understand there are no guarantees
- I acknowledge receiving verbal and/or written post-operative instructions

Please initial:

_____ I acknowledge that I have met with the doctor. I understand that additional questions can be answered any time by CoZmedic Surgery Associates or by the dr. on the day of surgery.

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I understand that it is essential that I have someone stay with me post operative for at least 24 to 48 hours. This is to certify that I will have someone at home on discharge. ☐ YES ☐ NO

I understand that I will be contacted 1-3 days before my surgery as well as after my surgery. I can be contacted by phone at the following numbers

Home ( ) _____

Work ( ) _____

Other ( ) _____

It is our policy to respect the confidentiality and privacy of our patients. No information will be given to any individual calling the day of surgery unless listed below:

_____

Name and Relationship Name and Relationship

It is our policy to respect the confidentiality and privacy of our patients. Please make the emergency contact below aware of the procedure you are having. At any time, in case of an emergency, please contact:

_____

Name and Relationship Phone Number

_____

Patients signature Date

CoZmedic Surgery Associates 1-800-B-YOUTHFUL