

Hawaii Family Physicians



David Arthurs, D.O.

Beth Catanzaro, M.D.

81-6587 Mamalahoa Hwy. Suite C201

Mailing address: P O Box 2060 Kealahou, Hawaii 96750

Phone: 808-323-3107 Fax: 808-323-0012

**INFORMED CONSENT
FOR
PROCEDURE / SURGERY / INJECTION**

I request Dr. Arthurs (circle one) or Dr. Catanzaro to perform the following:

(print type of procedure, surgery or injection:)

My signature below indicates that:

The technique of performing the procedure, or receiving the injection(s), and alternative treatments or risks have been discussed with me.

I understand that success is anticipated, but not guaranteed, and that complications including but not limited to: bleeding, scarring, infection, numbness or bruising, may occur from this procedure.

I have been given the opportunity to ask questions which have been answered to my satisfaction about this procedure.

This consent remains in effect for all visits related to the same procedure or for all visits where I receive the same injection. I understand and agree that **if my insurance company does not fully cover this procedure or my office visit, I am responsible for the balance.** If I have no insurance, I agree to pay for the procedure in full ahead of time.

Patient signature: _____ Date: _____

Printed name: _____

Witness: _____ Date: _____