MOUNTAIN
ORTHOPAEDICS

PAUL J JOHNSON, MD
BRYCE PACE, PA-C

CONSENT TO MEDICAL CARE

I hereby authorize my physician, Paul J. Johnson, M.D., and any associates or assistants of his choice to perform upon me;

Anterior Cervical Discectomy and Fusion

I recognize that, during the course of the procedure, unforeseen conditions may necessitate additional or different procedures than those explained. I, therefore, further authorize and request that my physician and any associates or assistants of his choice perform such procedures as are, in their professional judgment, necessary and desirable for my well-being. I further consent to the administration for such anesthesia as may be necessary or appropriate for such procedure.

I understand that the proposed care may involve risks and possibilities of complication and that certain complications have been known to follow this procedure to which I am consenting even when the utmost care, judgment and skill are used. I acknowledge that guarantees have not been made to me as to the results of the operation procedure and no guarantees made against unfavorable results.

I accept the risk of substantial and serious harm, if any, in hopes of obtaining desired beneficial results of such care. Further I acknowledge that the physicians involved have explained my condition, the proposed health care and alternative forms of treatment in a satisfactory manner and that all questions asked about the health care and Its attendant risks have been answered in a manner satisfactory to me.

I have read and understand this document and authorize and accept the proposed care regardless of the risk.

DATED this _____ day of _____, 20 _____.

_____ PATIENT'S SIGNATURE

_____ WITNESS

(If the patient is a minor or unable to sign, complete the following)

_____ PARENT OR GUARDIAN

_____ OTHER PERSON & RELATIONSHIP

_____ WITNESS