KNOXVILLE EYE SURGERY CENTER, LLC,
d/b/a TENNESSEE VALLEY EYE CENTER
CONSENT FOR SURGERY

Patient _____ Date _____ Time _____

I hereby authorize _____ to perform the following procedure

_____

_____

upon MYSELF (Name of patient or "myself").

I do voluntarily consent to the proposed course of treatment to be performed at Knoxville Eye Surgery Center, LLC, d/b/a Tennessee Valley Eye Center, ("Facility"). It has been fully explained to me that during the course of the procedure, it is always possible that unforeseen conditions may necessitate additional or different procedures than those described to me. I authorize and request that my physician, his assistants or his designees, perform such additional procedures as are necessary. The general nature of the anticipated surgery, the medically accepted alternative procedures, and the substantial risks inherent in the proposed treatment have been explained to me by my surgeon. I understand such risks and I consent to the procedure. I consent to transfer to a hospital in the event that my condition warrants such a transfer.

I understand that anesthesia bears some risk of either injury, allergic reaction, loss of vision or rarely death even when administered by the most competent Anesthetist, Anesthesiologist or Surgeon. I consent to the disposal of any tissue which is removed in accordance with the medical staff rules and regulations.

For the purpose of advancing medical education, I consent to the admittance of approved observers to the Operating Room. The facility may participate in training programs for allied health professionals. All care rendered by individuals in training will be supervised and reviewed by appropriate personnel. I hereby consent to care from individuals in training and to the review of my patient record by same. I consent to the photographing or video taping of the procedure, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them.

I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me throughout my surgery. I acknowledge that I have been advised by facility personnel not to drive until the effects of any medication have worn off. I understand this to mean that I should not drive until the day after my surgery or as directed by my physician.

If any employee or medical staff member of the Facility is exposed to my blood or other body fluids, I authorize the Facility to test my blood for Hepatitis B & C and HIV (the virus that causes AIDs). I understand the tests will be done at the expense of the Facility.

The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information.

_____ _____
Patient's Signature Witness Signature

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

_____ PATIENT is a minor -- _____ years of age
_____ PATIENT is unable to sign because _____

_____ _____
Closest Relative, Legal Guardian, or Interpreter (if applicable) Witness Signature