ARIZONA SPECIALIZED GYNECOLOGY, PLLC
OFFICE COLPOSCOPY CONSENT FORM / PROCEDURE

I, _____ (patient or guardian), authorize Dr. Joseph Brooks and/or associates to perform the following procedure (s) signified by my initials in the column next to the procedure (s) and my signature

Patient's Initials	Treatment with Description	Goals of the Treatment	Major Risks of the Treatment
	Colposcopy / Vulva	To magnify and visualize the vulva, vagina and cervix for evaluation of abnormality Please note that your insurance company may apply colposcopy – vulvoscopy towards your deductible.	No known major risks associated with this procedure. Please know that a colposcopy - vulvoscopy is performed at all new patient evaluations and at every visit. Your one time signature will serve as permission for each exam.
	Colposcopy with Possible Biopsy	To magnify and visualize abnormal tissue of the vulva, vagina and cervix and possibly take a small sample (s) of tissue (biopsy) to be sent to the lab for evaluation and diagnosis. A local anesthetic is usually used. Unless otherwise indicated by Dr. Brooks.	No known major risks associated with this procedure. You may have very little bleeding and biopsy site pain. Please contact the office if this occurs. **Please note that you may be billed by outside sources other than Dr. Brooks's office.**

GENERAL RISKS AND POSSIBLE COMPLICATIONS: This authorization is given with the understanding that any procedure involves some risk and possible complication. I consent to my doctor/provider to do anything necessary to save my life, to remove, repair any damaged or diseased tissue, and/or respond to an emergency appropriately. Other risks not listed on this form are also a possible complication as well.

PERFECT RESULTS CANNOT BE AND ARE NOT GUARANTEED I understand that no guarantees have been made as to the result of this procedure and that it may not completely cure or evaluate the condition or which it was recommended.

PATIENT'S ACKNOWLEDGEMENT OF INFORMED CONSENT I have read and fully understand this consent form, I understand I should not sign below unless all of my questions and concerns have been explained or answered to my completer satisfaction, or if I do not understand, or if I do not understand any of the terms or words contained in this consent form or any of the discussions with my physician. I have no further questions. I believe I have been adequately informed and I consent to the above procedure/medication.

PLEASE DO NO SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

_____ **Patient/Responsible Party Signature/DATE**