BRAVERMAN
Reproductive
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Answers for Recurrent Pregnancy Loss

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Consent/Authorization for Treatment

Consent for Treatment: I hereby authorize Dr._____, his/her associates and/or assistants ("Physician") to perform the treatment(s) described below. I have been informed of and understand the reasons for the treatment/procedure(s), along with the expected benefits, risks of, and alternatives to the following (please mark the appropriate procedure(s):

☐ Office hysteroscopy with or without removal of uterine polyps, with or without removal of scar tissue

☐ Endometrial biopsy

☐ Uterine mapping

☐ I understand that some of the risks may include, but are not limited to: infection, bleeding, and perforation of the uterus.

I hereby authorize and direct Dr. Braverman to provide such additional services for me as he/she may deem reasonable and necessary, including but not limited to, the administration of local anesthesia and the performance of services involving pathology or laboratory tests, and I hereby consent thereto.

I certify that no guarantee or assurance has been made to me as to the results that may be obtained. In consideration of having the treatment noted above available to me, I hereby release Dr. Braverman and his associates, Braverman Reproductive Immunology P.C. and its employees, agents, and affiliates, and any person or corporation acting as an employee, agent, or affiliate, from any and all liability except for negligence, arising out of this matter.

_____	_____	_____
Female Patient Name	Date	Patient Signature
_____	_____	_____
Witness Name, Credential (Printed)	Date	Witness Signature

The patient named above has been advised of the risks, benefits and alternatives to the treatment referenced herein, has been given an opportunity to ask any questions, and has acknowledged understanding and consent to proceed.

_____	_____
Jeffrey Braverman, M.D.	Date