Female Patient Name: _____ **Social Security #:** _____

Male Patient Name: _____ **Social Security #:** _____

New England Fertility Institute

1275 Summer Street • Suite 201 • Stamford, CT 06905 • Tel: (203) 325-3200 • Fax: (203) 323-3130

OVARIAN CYST ASPIRATION

Description, Explanation and Informed Consent

I hereby consent to undergo ovarian cyst aspiration. I understand that this is done through the use of a vaginal ultrasound probe that has a special needle located along the side of the probe. This needle goes through the vaginal wall and aspirates the fluid from the cystic structure located in or on the ovary. I understand that some of the possible risks of ovarian cyst aspiration are, but are not limited to:

1. Damage to adjacent structures.
2. Bleeding and/or infection.
3. Recurrence of the ovarian cyst.
4. Adverse effects of anesthesia or analgesics.

I hereby consent to the administration of such anesthetics as may be considered necessary or advisable by my physician with the exception of: _____

I do hereby sign and consent to pay any charges incurred related to this procedure. It is my understanding that there is a direct charge for the procedure itself and that there may be a separate sedation charge, consultation fee and/or laboratory charges. In the occurrence that the insurance carrier denies my eligibility or coverage for these services, I will be fully responsible for remittance of all fees.

Allergies: _____

I acknowledge that all of my questions concerning this procedure have been answered.

_____	_____	_____
Date	Signature of Patient	Patient Name - Print

As one of the members of New England Fertility Institute, by my signature indicate that the foregoing consent was read, discussed and signed in my presence.

_____	_____	_____
Date	Signature of Witness	Witness Name - Print