BayArea Podiatry Associates
A Professional Association
Medicine and Surgery of the Foot
*Board Certified in Foot and Ankle Surgery
bayareapodiatry.com

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*Matthew S. Rockett DPM
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Diplomates, American Board Podiatric Surgery
Fellows American College of Foot Surgeons
Dedicated to providing the finest quality foot and ankle care

This form is designed to comply with the requirements promulgated by the Texas Medical Disclosure Panel

DISCLOSURE AND CONSENT
MEDICAL AND SURGICAL PROCEDURES

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Dr. Kirk A. Koepsel.
as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as: Malunion of Metatarsal 4th, Left foot and 3rd metatarsal left foot.

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me an I (we) voluntarily consent and authorize these procedures: Open reduction with internal fixation 4th Metatarsal, Left foot and third metatarsal left foot

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgement.

I (we) (do) (do not) consent to the use of blood and blood products as deemed necessary.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure: Recurrence, Infection, Painful scar, continued pain, excessive swelling, nerve damage, Tendon damage, Complex Regional pain syndrome. delayed healing

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

KAKoepsel

PATIENT/GUARDIAN SIGNATURE: Beth Armatta

PATIENT NAME: Beth Armatta DATE 5/22/09

WITNESS SIGNATURE: Agm TIME 10:45 A.M. P.M.

1234 Bay Area Blvd., Suite G
2017 E. Broadway, Suite B
Houston, Texas 77058
Pearland, Texas 77581
(281) 488-3237
Fax (281) 488-4218

Houston Physician's Hospital

Ownership and Insurance Plan Disclosure

Thank you for choosing Houston Physician's Hospital for your surgical care. We take that choice seriously and will do everything we can to keep you comfortable with that decision. In fact, your physician may be a part owner in our hospital which means that physicians have direct participation in decisions that are made about the facility. If you would like to see if your physician is also a part owner, please ask, we will be happy to furnish you a list.

Our facility **may not** be included on your health insurance plan, but we appreciate your business and will honor you benefits as if we were on your plan. We have contacted your insurance company and have confirmed with them your in-network benefits. We have notified your insurance company that we intend to honor the co-pay portion of your in-network benefits. If you receive a statement from your insurance company stating you owe something different, please call and let us help you.

In addition to your surgeon, there are many other physicians that may be involved in your care and will bill separately from us. You should contact the following to confirm their status with your insurance company and make arrangements for payment directly with them:

- Anesthesiologists (Texas Anesthesia Group): 281-348-0431
- Radiologists (Gulf Imagine Associates): 281-880-1852
- Pathologists (Baylor Pathology): 713-798-3677

Additionally, for your comfort and safety, we have at least one physician in house twenty-four hours a day, seven days a week.

Please do not hesitate to contact one of our financial counselors at 281-557-5620 if you have any questions.

Please sign: X Beth Arnatta

Date: 5/20/09

Beth Armatta
DOB: 10/26/62

HOUSTON PHYSICIANS' HOSPITAL
333 N. Texas Avenue / Webster, TX 77598
Tel: (281) 335-1700 / Fax: (281) 335-1708

HISTORY

Present Complaint: Malunion metatarsal 4th (L) foot

Past History:
Surgeries (☐ None) Gall bladder 6/03, Appendicitis '94, Broken Foot '92
Medical Illness (☐ None) H/o PC, HTN, GERD
Current Medications (☐ None) Lisinopril/HCTZ 20/25, Lisinopril 20mg, Omeprazole 20mg, ASA 81mg
Allergies (☒ None)
Smoke (☒ None) ____ Alcohol (☐ None) X Social ETOH
Psychosocial: WM

PHYSICAL

General (☑ Alert, Oriented, NAD)
HEENT (☑ No mass or deformity)
Torso/Breast (☑ No mass or deformity)
Heart (☑ Normal rhythm, no mumur or gallop)
Lungs (☑ clear to ausculation)
Abdomen (☑ No mass or tenderness)
Pelvis/Rectal (☐ No mass or tenderness) Deformed — WWE c Dr Rao 1 month ago WNL
Extremities (☑ No edema or deformity)
Neurological (☑ Intact)

Impression: H/o PC, s/p treatment & LFT's. Well controlled HTN + GERD. Malunion (L) foot fx
Plan: Will obtain labs for pre-op clearance + fax to Podiatry when back
(☐ see office H&P)

Pt. O.K. for surgery if Coag studies WNL + labs acceptable to anesthesia.

Signed: [signature] ,M.D.
Attending Physician
Date/Time: 5/21/09

REPORT OF OPERATION (☐ None)

Anesthetic ☐ General ☐ Spinal ☐ Epidural ☐ IV Sedation ☐ Local

Pre-Op Dx
Post-Op DX
Procedure
Surgeon/Assistant
Significant Findings

Specimens Removed (☐ None)

Estimated blood Loss (☐ None) ____ ml
complications (☐ None)

Signed: ____ ,M.D.
Attending Physician
Date/Time:

POST OP ORDERS (☐ See order sheet)

DISCHARGE NOTE

Significant Findings (☐ As above)

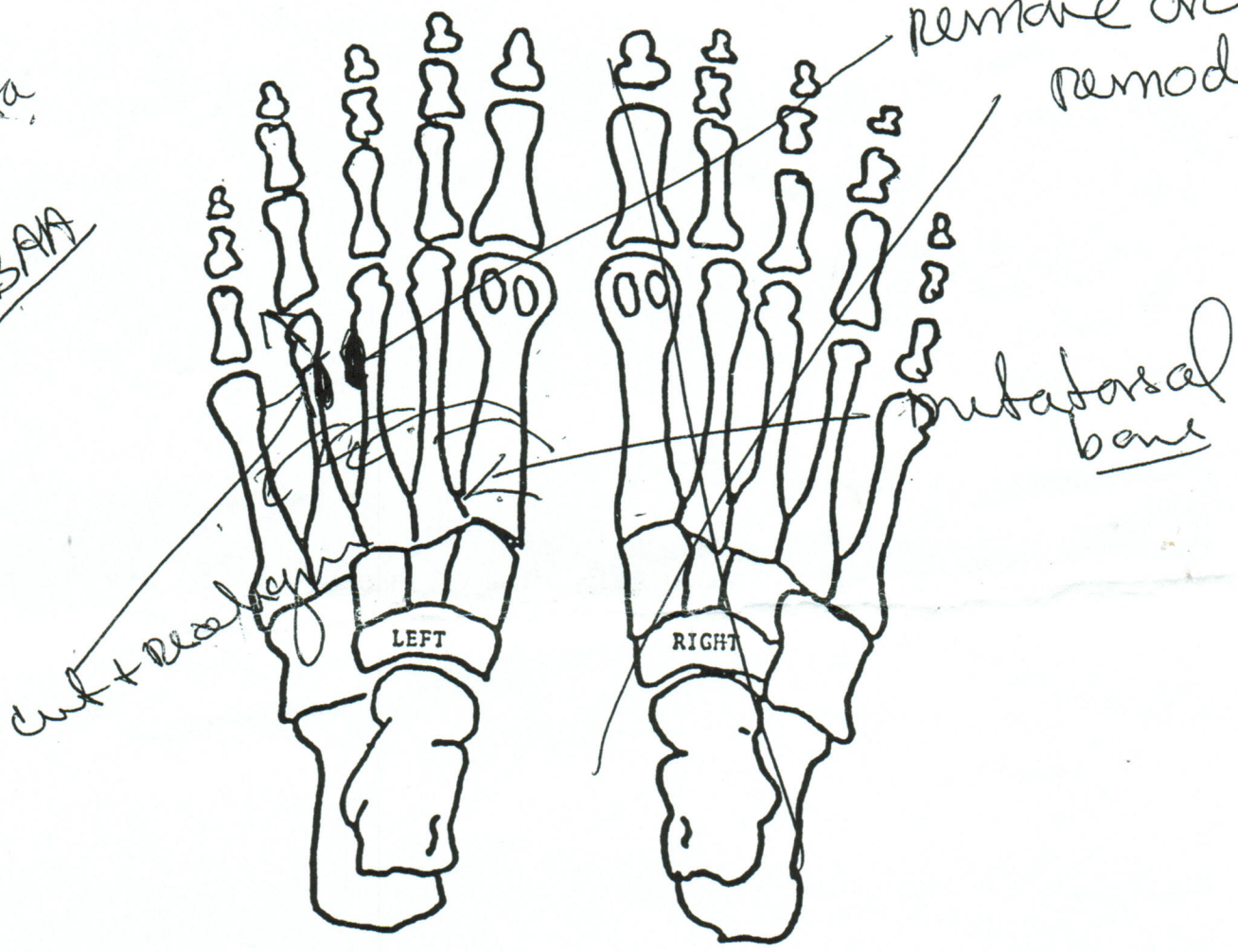
Treatment Rendered (☐ As above)

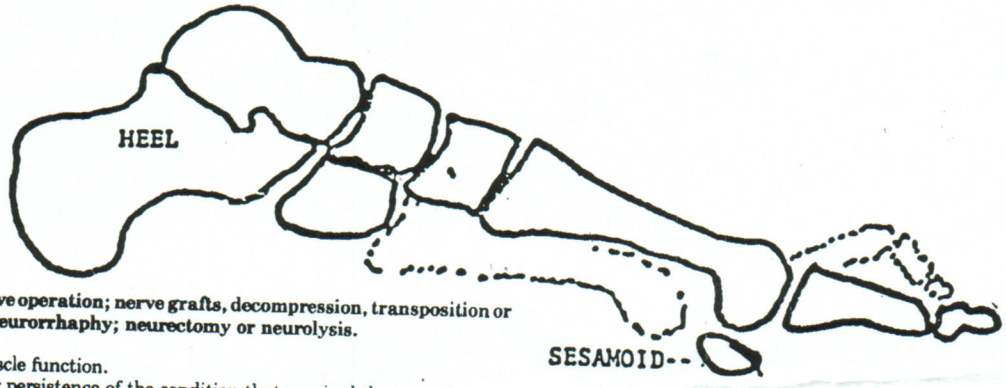
Condition on Discharge (☐ Stable)
DC Instructions (☐ As per D/C Inst. Sheet

Diet (☐ Resume pre-op diet)
Activity (☐ As tolerated)
Medications Prescribed on Discharge (☐ None)

Follow (☐ PRN) ____ day's ____ weeks
Final DX (☐ As above)

Signed: ____ ,M.D.
Attending Physician
Date/Time:





4. Peripheral nerve operation; nerve grafts, decompression, transposition or tumor removal; neurorrhaphy; neurectomy or neurolysis.

1. Numbness.
2. Impaired muscle function.
3. Recurrence or persistence of the condition that required the operation.
4. Continued; increase or different pain.

Musculoskeletal system treatments and procedures

(A) Arthroplasty of all joints with mechanical device.
- (i) Impaired function such as shortening or deformity of an arm or leg, limp or foot drop.
- (ii) Blood vessel or nerve injury.
- (iii) Pain or discomfort.
- (iv) Fat escaping from bone with possible damage to a vital organ.
- (v) Failure of bone to heal.
- (vi) Bone infection.
- (vii) Removal or replacement of any implanted device or material.

(B) Mechanical internal prosthetic device
- (i) Imparied function such as shortening or deformity of an arm, leg, limp or foot drop.
- (ii) Blood vessel or nerve injury.
- (iii) Pain or discomfort.
- (iv) Fat escaping from bone with possible damage to a vital organ.
- (v) Failure of bone to heal.
- (vi) Bone infection
- (vii) Removal or replacement of any implanted device or material

(C) Open reduction with internal fixation.
- (i) Impaired function such as shortening or deformity of an arm or leg, limp or foot drop.
- (ii) Blood vessel or nerve injury.
- (iii) Pain or discomfort.
- (iv) Fat escaping from bone with possible damage to a vital organ.
- (v) Failure of bone to heal.
- (vi) Bone infection.
- (vii) Removal or replacement of any implanted device or material.

(D) Osteotomy.
- (i) Impaired function such as shortening or deformity of an arm or leg, limp or foot drop.
- (ii) Blood vessel or nerve injury.
- (iii) Pain or discomfort.
- (iv) Fat escaping from bone with possible damage to a vital organ.
- (v) Failure of bone to heal.
- (vi) Bone infection.
- (vii) Removal or replacement of any implanted device or material.

(E) Ligamentous reconstruction of joints.
- (i) Failure of reconstruction to work.
- (ii) Continued loosening of the joint.
- (iii) Degenerative arthritis.
- (iv) Continued pain.
- (v) Increased stiffening.
- (vi) Blood vessel or nerve injury.
- (vii) Cosmetic and/or functional deformity.

(F) Children's orthopedics (bone, joint, ligament or muscle).
- (i) Growth deformity.