S.E. PA
PAIN MANAGEMENT

Procedure Consent Form

Patient Name:		**Age:**	**Sex: M F**
Address:		**Birth Date:**	
Surgeon:	**Date of Surgery:**	**Home Phone:** **Cell Phone:**	

CONSENT TO OPERATION AND RENDERING OF MEDICAL SERVICES

☐ Cervical Epidural Steroid ☐ Cervical Facet Block ☐ Cervical Foraminal Epidural ☐ Biaculoplasty ☐ Discogram ☐ Extradural Myelogram ☐ Intercostal Nerve injection Medial Branch Blocks ☐ Ilioinguinal/Genitofemerol Injection ☐ Major Joint Injection: _____	☐ Lumbar Epidural Steroid ☐ Lumbar Epidural Lysis ☐ Lumbar Facet Block ☐ Lumbar Foraminal Epidural ☐ Lumbar Sympathetic Block ☐ Lumbar Sympathectomy ☐ Pump Refil ☐ Medial Branch Rhizotomy ☐ Vertebroplasty ☐ Other: _____	☐ Occipital Nerve Block ☐ Sacroiliac Injection/ Arthrogram ☐ Selective Nerve Block/ Neurogram ☐ Thoracic Epidural Steroid ☐ Thoracic Facet Injection ☐ Thoracic Sympathetic Block ☐ Trigger Point Injection ☐ Trial Spinal Cord Stimulator ☐ Right ☐ Left ☐ Bilateral

I, the above mentioned patient hereby authorize the above-named surgeon and/ or associates or assistants of his choice to perform the operation indicated above and/or such operations and/ or any other therapeutic procedures upon me they may deem necessary or advisable. The necessity for the operation, the potential benefits, alternatives, and the potential risks of the operation have been explained to me and no warranty or guarantee has been made as to the result or cure. I have been advised of the comparative risks, benefits and alternatives associated with performing the procedure in an office or surgical center instead of a hospital.

I hereby authorize the above named surgeon and/ or his associates or assistants to provide such additional services for me as he or they may deem necessary or advisable including procedures different from those now contemplated, and including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology, and I hereby consent thereto.

The risks of the procedure including potential problems that might occur during recuperation include but are not limited to increased pain, bleeding, infection, headache, nerve/spinal cord injury, and/or loss of sensory or motor function, seizure death.

I authorize members of the anesthesia staff to prescribe and use any such anesthetics and/or adjunct agents, as they may consider advisable.

I/We Hereby authorize all doctors, pharmacists, hospitals, S.E. PA Pain Management or other institutions rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered, (including copies of my records). A photo-static copy of this authorization shall be considered as effective and valid as the original.

NOTICE: Any legal claim or civil action, including, but not limited to, a claim for medical malpractice in any way related to this admission/procedure, and the medical services provided by S.E. PA Pain Management or it's employees, shall be brought solely in the Courts of Montgomery County, in the Commonwealth of Pennsylvania.

If patient or undersigned does not agree to the above paragraph, then he/she will initial here._____

The undersigned certifies that he/she has read the above and is the patient, parent, guardian or representative authorized to execute the above and accept its terms and risks.

PATIENT SIGNATURE_____

SURGEON'S SIGNATURE_____ DATE_____

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

because,_____

Parent/Guardian Relationship Surgeon Signature Date