Total Pain & Spine Care of Florida

Patient Name: _____

DOB: _____

INFORMED CONSENT FOR MEDICAL, SURGICAL, DIAGNOSTIC PROCEDURES

My physician explained to me that I have been diagnosed as having the following condition:_____

_____

My physician has recommended and I request and authorize the following **procedure(s):**

_____

_____

which will involve appropriate anesthesia and may include the use of blood products unless otherwise noted on the Blood or Blood Components Consent Form.

2. Through agreement with my physician, I understand that the procedure(s) will be performed by my physician and/or his or her designated assistants at one of the facilities of Total Pain & Spine Care of Florida. I understand that healthcare industry representative(s) or similar visitors may be present in the operating room based on the discretion and approval of the physician and hospital, and I give my consent to this.

3. I have been advised of possible risks and consequences associated with the recommended procedure including but not limited to: *bleeding, infection, no pain relief, increased pain during procedure, increased Pain following procedure, increased weakness, damage to surrounding or nearby structures, nerve damage, pneumothorax, paralysis, headache, and/or death*

4. I understand that I have the option to do nothing, and the possible risks and consequences may include: *continued pain*

5. I understand that, in addition to doing nothing, there are alternatives to the recommended procedure including: *Physical therapy, medication management, observation or injection at other adjacent sites as clinically indicated during the procedure*

I have been advised of possible risks and benefits of these alternatives as they compare to the recommended procedure including: *noted above*

6. I have been advised that sometimes during a procedure it is discovered that an **additional procedure** is needed immediately. Except as noted below, I authorize my physician to proceed with such additional procedures: (If no exception, write "none") *none*

7. I acknowledge that **no guarantees** as to outcomes have been made concerning this procedure. I have been advised that if I desire, my physician will give me a further or more detailed explanation concerning my diagnosis, recommended and alternative procedures, potential benefits, or possible risks and consequences. I am satisfied with the explanation given to me and authorize my physician and others as may be selected by my physician to perform the recommended procedure noted above.

8. I understand and give my permission that anything removed from me during the procedure (1) will be examined and reported according to clinic policies; (2) will be disposed of in a manner deemed appropriate by the clinic; and (3) may be used for scientific, developmental technology, research, or education purposes.

9. I understand and give my permission that photographic, video, or audio recordings or images of the procedure outlined above may be made for purposes of medical documentation, research, or education. I understand that I may request cessation of filming or recording at any time, and I may rescind my consent to the use of the images up to a reasonable time before it is to be used.

10. I have communicated my desires regarding suspension, modification, or continuation of my "Do Not Resuscitate" status with my physician and/or his or her associates or assistants (if applicable).

Patient or Legal Representative Signature:_____ Date:_____ Time:_____ am pm

Witness Signature:_____ Date:_____ Time:_____ am pm

I have personally explained the above information to the patient or the patient's legal representative:

Provider Signature: _____ Date:_____ Time:_____ am pm