PAIN SPINE & REHAB ASSOCIATES

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CONSENT TO PAIN MANAGEMENT PROCEDURE

I, _____, do hereby authorize

Dr. Mohsin Sheikh Dr. Mariam Razaq

and associates or assistants as may be selected by him/her to perform the following procedure(s):

_____ (Medical term)

_____ (Layman's terms)

I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedure have been explained to me as well as the possible risks and benefits of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. No guarantee or assurance has been given by anyone as to the results that may be obtained from this procedure.

I certify that I have read and fully understand the provided Consent statement, which has been preceded by an explanation by my physician/physician assistant/nurse practitioner and that said explanations are understood by me. All blanks or statements requiring insertion or completion on this form were filled in before I signed it.

_____ Time _____ _____
Signature of Patient Date _____ Witness Signature

_____ Time _____ _____
Signature of Person Authorized to Consent Date _____ Relationship to Patient

_____
Witness Signature

CERTIFICATION OF PROVIDER:

I certify that I have discussed the risks, benefits and alternatives of the proposed procedure(s) with the patient or authorized representative and that he/she consents.

_____ Time _____ AM / PM
Signature of Physician, Physician Assistant or Nurse Practitioner

Date _____