MANHATTAN PAIN MEDICINE, PLLC

CONSENT TO PROCEDURE / TREATMENT

1. I hereby authorize Jason Siefferman, MD and/or those associates or assistants he may designate to perform upon ME / _________________________ the following treatment(s) or procedure(s):

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2. Dr. Jason Siefferman has fully explained to me in language I understand the nature of the proposed care, treatment, services, interventions, procedures and/or medications and has also informed me of the potential benefits, risks or side effects, including potential problems that might arise during recuperation. I have been informed of the likelihood of achieving the proposed goals and of the reasonable alternatives to the proposed plan of care. I have been informed of the relevant risks, benefits and side effects related to alternatives including the possible results of not receiving the proposed treatment. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

3. I understand that, during the course of the above proposed treatment/procedure, unforeseen conditions may arise which necessitate surgery/treatment/procedure different from those contemplated. I consent to the performance of additional surgery/treatment/procedure which the above-named physician or his/her associates/assistants may consider necessary.

4. I understand that I may require the administration of anesthetics/sedatives/analgesics deemed necessary under the direction of an authorized provider. I understand that I will be made aware of the risks, benefits of, and alternatives to the administration of anesthetics/sedatives/analgesics prior to the surgery/procedure/treatment by an authorized provider.

5. I further consent to the transfusion of blood or blood components as deemed necessary for the proposed surgery/treatment/procedure. I have been made aware of the risks, benefits of, and alternatives to the administration of these products.

6. I have been advised of limitations on the confidentiality of information about me that are related to the proposed plan of treatment.

7. Any tissues/body fluids surgically removed may be examined and retained by a laboratory for medical purposes, and such tissues or body fluids may be disposed of in accordance with customary practice.

8. I consent to the photographing, videotaping and/or closed circuit televising, and publication thereof, of this treatment/procedure for medical, scientific or educational purposes, provided my identity is not revealed.

9. I understand that during the course of the treatment/procedure, a manufacturer's representative may provide technical support.

10. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the proposed treatment/procedure. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

11. I have crossed our and initialed any paragraphs to which I do not consent.

Patient / Relative / Guardian Name: ____

Relationship (if not patient): ____________________________

Signature: ____

Date: ______________________ Time: _____________________ AM / PM

I, Jason Siefferman, MD, hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed procedure/treatment, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered. In the event that I was not present when the patient signed this form, I understand that the form is the only documentation that the informed consent process took place. I remain responsible for having obtained the consent from the patient.

Physician Signature: ____________________________

Date: ______________________ Time: ______________________ AM / PM