MAASUMI

HEADACHE & SPINE CARE

Consent Form

NOTE TO PATIENT There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment. I authorize Maasumi Headache and Spine Care providers and such physicians, associates, assistance, and other personnel or the hospital or medical facility chosen by the provider to perform the practice of medicine with the intention to improve my general well-being as discussed with me. At the time of the treatment I understand I can authorize any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the recommended procedure.
GENERAL RISKS AND COMPLICATIONS I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described to me in discussion with my provider. These risks include, yet are not limited to, the risk of bleeding, infection, pain, injury to neurovascular structures which controls sensation, motor function and viability to the procedural region as well as anesthesia risks and death.
SPECIFIC RISKS AND COMPLICATIONS I am satisfied with my understanding of specific risks of this procedure or treatment as described to me in discussion with my provider.
ALTERNATIVE METHODS OF TREATMENT I am satisfied with my understanding of the alternative procedures or treatments and their possible benefits and risks as described to me in my discussion with my provider.
NO TREATMENT I am satisfied with my understanding of the possible consequences, outcomes, or risks if no treatment is rendered. I also understand no treatment is always an option if I do not want to take the above discussed procedure or treatment risks.
SECOND OPINION I understand I can be offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.
ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE & TREATMENT I understand that conditions may arise which are unforeseen at the time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.
OTHER SERVICES I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue, hardware, or member in accordance with customary hospital or medical facility practice.
PHOTOGRAPHY I consent to the photographing, filming, or videotaping of the treatment or procedure for educational or diagnostic use.
NO GUARANTEES I understand there are risks involved in my procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.
FINANCIAL POLICY I understand that even if I have insurance, I may incur charges that are my responsibility. I understand that it is my responsibility to know my benefits and deductible information and whether or not the treatment I am about to have is covered. if my deductible has not been met, or my insurance carrier denies this procedure, I understand that the financial responsibilities in mind and that this office will build me for services not covered or paid four by my insurance period if you're insured with a plan we are not contracted with, you are required to pay for this visit in full, at the time of the service.

OTHER QUESTIONS I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read this form thoroughly.

Date:
Patient name:
Signature of patient, parent, or legal guardian: