East Side Endoscopy & Pain Management Center
Informed Consent for Pain Management Procedure

I hereby authorize Dr. Daniel Hanono, and whomever he/she may designate as his/her associates and/or assistant's to perform the following operative or diagnostic procedure(s) including the injection of local anesthesia

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This procedure has been explained to me in terms I understand. **I understand that the procedure may include an injection of an anesthetic or steroid or other therapeutic substance in and around specified nerves/ muscles or joints and that fluoroscopy/radiation may be used. I understand if I am or could be pregnant I have been informed of the specific risks, including adverse effects to me and /or my embryo fetus and the risks associated with this x-ray procedure during pregnancy. I understand;**

- The benefit, purpose, nature and extent of the procedure(s) to be performed;
- Potential risks include, but are not limited to: headache, infection, bleeding, and allergic reaction. Increased pain, nerve damage, or other neurological injury are rare potential complications.
- Alternative treatment options include but are not limited to medication management, physical therapy, acupuncture and surgery
- The danger and possible consequences of such alternatives including no procedure or treatment.
- The estimated period of incapacity and the estimated period of convalescence (assuming there are no complications);
- The expected consequences of the procedure upon my future health.

To keep you comfortable during the procedure, medication, defined as Deep Sedation, will be administered by an anesthesia provider (Anesthesiologist) as defined in the anesthesia consent. In the event an anesthesia provider is not utilized, your physician may administer medication defined as Conscious/Moderate Sedation.

1. I have asked all of the questions I thought were important in deciding whether or not to undergo treatment or diagnosis. Those questions have been answered completely to my full satisfaction.
2. I understand no assurance can be given that the procedure will be successful and relieve my pain, and no guarantee or warranty of success or cure has been given to me.
3. I further authorize and request my physician and his/her associates, assistants, and appropriate center personnel to perform such additional procedures which in their judgment are incidentally necessary or appropriate to carry out my diagnosis / treatment.
4. I hereby authorize the above named surgeon to use his discretion in the retention, preservation, or disposal of any tissue or member consistent with the center's policies and procedures.
5. I consent to the taking of any photographs, videotaping, and other visual recordings, during my procedure to assist in my care and for use in the advancement of medical education; for the presence of an observer during the procedure to provide assistance or consultation services to the physician
6. I understand that I have been advised that should not drive for twenty four (24) hours following my procedure. I also understand that in the event of cardiac or respiratory arrest or other life threatening situation during my admission, the Center will perform necessary life saving measures until transferred to a hospital should such methods become necessary and that my Advance Directives will not be honored the Center. I give my consent for any medical treatment deemed necessary including transfer to a higher level of care.
7. I consent to the drawing and testing of my blood in the event that an individual is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential, except as specified by law.
8. I consent to having a peer physician review my medical record to obtain information about the delivery of medical care.
9. I have read this document and understand it. I have been given the opportunity to ask my physician questions, and my questions have been answered to my satisfaction. I am aware that I have the right to secure a second medical opinion.

If any unforeseen condition arises during the procedure calling for, in the physician's judgment, additional procedures, treatments, or operations, I authorize him/her to do whatever he/she deems advisable. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of this procedure. If there is any question that I might be pregnant, I will allow a urine pregnancy test to be performed prior to my procedure.

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Signature Patient or Legal Representative Date/Time

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Signature Witness Signature of Physician