ENCOMPASS MEDICAL GROUP

CONSENT TO PROCEDURE OR TREATMENT

Date: _____ Time: _____

I, _____ hereby authorize _____ to perform
(patient name) (physician / provider)

the following procedure or treatment: **joint injection of** _____

I have been informed and understand the nature and purpose of the procedure or treatment; the probable consequences thereof and any alternative methods of treatment; the possibility of occurrence of complications has been explained and is understood by me, and I acknowledge that no guarantee or assurance has been made as to the results to be obtained. Risks of this procedure may include, but are not limited to: **post injection pain, infection, bleeding, damage to nearby structures, failure of procedure, recurrence of problem, reaction to local anesthetic or steroid, skin depigmentation, fat necrosis**.

It has been explained to me that during the course of the procedure; unforeseen conditions may be revealed that necessitate an extension of the procedure or a different procedure than that set forth above. I hereby authorize and request the above-named physician or his designated consultant to perform such procedures that are necessary and desirable in the exercise of the physician's professional judgement. The authority granted shall extend to the treating all conditions that require treatment, which are not known to the physician at the time the procedure commenced.

I also consent to the pathological study and retention or disposal of any tissue or parts, which may be removed during the above procedure.

I certify that I have fully read and understand the above consent to procedure or treatment, that the explanations therein referred to were made, and that all my questions regarding this procedure have been completely answered.

_____ _____
(Printed name of patient) (Signature of patient or guardian)

_____
(Relationship, if not patient)

_____ _____
(Printed name/witness) (Signature of witness)

_____ _____
(Printed name of physician/provider) (Signature of physician/provider)