COVENANT SPINE AND NEUROLOGY, PLLC
DISCLOSURE AND CONSENT FOR PROCEDURES

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you; it is to an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I authorize the performance of the following described procedure upon _____
2. I voluntarily request (Bryant, Powers, Runheim) as my physician and such associate and assistants as are deemed necessary to perform the following surgical, medical, or diagnostic procedure(s) that are planned for me, and I voluntarily consent and authorize these procedures: _____

   _____
3. I also consent to such different or additional procedure(s) that are considered therapeutically necessary and advisable, based on my Providers finding during the course of my procedure(s).
4. I consent to the presence of manufacturer representatives, students, or observers in the operating room and have met and been informed of their presence by my provider.
5. Just as there may be risks and hazards in continuing my present condition without treatment, these are also risks and hazards associated with the performance of the surgical, medical, or diagnostic procedure(s) planned for me. I realize that common to surgical, medical, and diagnostic procedures is the potential for infection, blood clots in veins or lungs, hemorrhage, allergic reactions, and even death. My physician has discussed with me the nature or purpose of the proposed procedure(s), the particular risks and hazards associated with this procedure(s), including the risk the procedure(s) may not accomplish the desired result, the possible or likely consequences of the procedure(s); the feasible alternatives treatments (including risks, consequences, and probably effectiveness of these alternatives) and the prognosis if no treatment is received. No guarantees have been made to me concerning the results of the proposed procedure(s).
6. I consent to the release of my social security number as requested by medical device manufacturers as applicable.
7. I consent to being photographed, audiotaped, and or recorded for medical, scientific, or educational purposes. Filming or photographing of an operation or procedure may include appropriate portions of my body, provided my identity is not revealed in the pictures or by descriptive texts accompanying them.
8. I consent to the use of positioning/safety devices during the procedure.
9. I consent to the administration of medication as may be considered necessary or advisable during the procedure(s) planned for me.
10. I understand that local and/or oral sedation with valium may be provided for the procedure and if valium is taken, I was informed and have a driver to provide transportation home following the procedure.
11. I certify this form has been explained to my satisfaction, that I have read it or had had it read to me and the blank spaces have been filled in. I have been given the opportunity to ask questions about my condition, alternative forms of treatment, risks of treatment, and procedure(s) to be used, and the risks and hazards involved, and I believe that I have sufficient information to give consent.

Patient signature: _____ Date: _____ Time: _____

Witness signature: _____Date: _____Time: _____