THE SPINE + PAIN INSTITUTE

INFORMED CONSENT

Date: _____ Patient Name: _____ DOB: _____

Account #: _____ Physician: _____

I voluntarily consent to medical care, which may include routine office visits, diagnostic procedures and other therapeutic interventions and medical treatment by my physician, his / her assistants, or his / her designees, as is necessary in his / her judgment. Medical care may also be provided by the Nurse Practitioner, technicians, therapists and other providers which are supervised by qualified physicians. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of services, procedures, treatments or examinations at The Spine and Pain Institute.

This consent is designed to cover all procedures in The Spine and Pain Institute which do not require an additional "Special Consent Form."

It is anticipated that I (the patient) will require a series of services and this Consent to Treat shall cover all services while I am a patient at The Spine and Pain Institute.

Patient / Representative Initials: _____

I, _____ have read this form and I fully understand and accept
(Patient / Patient Representative)
its terms and conditions.

Patient / Representative Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____