

**PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND  
ACKNOWLEDGEMENT OF RECEIPT OF MEDICAL INFORMATION**

INFORMATION ABOUT THIS DOCUMENT  
READ CAREFULLY BEFORE SIGNING

**TO THE PATIENT:** You have been told that you should consider medical treatment/surgery. Louisiana law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, (4) reasonable therapeutic alternatives and material risks associated with such alternatives, and (5) risks of no treatment.

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 may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read carefully. Ask about anything you do not understand, and we will be pleased to explain.

1) Patient name: \_\_\_\_\_

2) Treatment/procedure:

a) Description, nature of the treatment/procedure: Radiofrequency Ablation of the Medial Branch Nerves of the Cervical Spine

b) Purpose: \_\_\_\_\_

3) Patient Condition:

Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in Item 2 indicated and recommended: \_\_\_\_\_

4) Material risks of treatment procedures:

a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.

See attached for risks identified by the Louisiana Medical Disclosure Panel

Risks determined by your doctor are Back Pain, Bruising, Permanent Nerve Root Damage, Inadequate Pain Relief, Drug Allergy, Death, Epidural Hematoma, Infection, Meningitis, Paralysis, Seizure, Stroke, Quadriplegia

b) Additional risks (if any) particular to the patient because of a complicating medical condition are: \_\_\_\_\_

c) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, quadriplegia (paralysis from the neck down), paraplegia (paralysis from the waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.

5) Reasonable therapeutic alternatives and risks associated therewith, risks of no treatment: \_\_\_\_\_

6) ACKNOWLEDGEMENT  
AUTHORIZATION AND CONSENT

- a) No Guarantees: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternative procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either expressed or implied, as to the success or other respects of the medical treatment or surgical procedure.
- b) Additional information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.
- c) Particular Concerns: I have had an opportunity to disclose to and discuss with the physician proving such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.
- d) Questions: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.
- e) Authorized Physician: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in Item 2 is: **Michael Zeringue MD**
- f) Physician Certification: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

Physician Signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

**CONSENT**

Consent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in Item 2 of this Consent Form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in Item 2 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

\_\_\_\_\_  
Patient or Person authorized to consent

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date/Time

If someone other than the patient signs consent, state the reason and relationship: \_\_\_\_\_

\_\_\_\_\_