

**COMPREHENSIVE PAIN MANAGEMENT  
OF THE FOX VALLEY, SC  
AUTHORIZATION FOR PROCEDURE**

I, \_\_\_\_\_ for myself, a minor child or another person for whom I have authority to sign, consent to and authorize (Provider) \_\_\_\_\_ to perform the following procedure(s) \_\_\_\_\_

1. It has been explained to me that during the course of the procedure, unanticipated conditions may be found and may require other diagnostic or therapeutic interventions.
2. The Provider (Physician or Nurse Practitioner) has discussed with me:
  - The nature and purpose of the proposed procedure.
  - The risks of the proposed procedure, including the risk that the procedure may not accomplish the desired result.
  - The possible or likely outcome of the proposed procedure.
  - Alternative treatments, including other available procedures or choosing not to have this procedure (including the risks and probable effectiveness of each alternative).
3. I understand that the facility participates in health care education or training programs and agree that at times health care services may be performed, or observed, by students or trainees under appropriate supervision.
4. At times my procedure may be observed by an equipment representative under the supervision of my Provider or other authorized facility personnel.
5. I consent to the photographing or videotaping that the Provider deems necessary for my medical record.
6. Unless listed here, I do not wish to limit the procedure to be performed.
7. I have had sufficient opportunity to discuss my condition and the proposed procedure with the Provider, and all of my questions have been answered to my satisfaction. I believe that I have adequate information upon which to base an informed consent.

**I CERTIFY THAT I HAVE READ/HAD READ TO ME AND FULLY UNDERSTAND THE CONTENTS OF THE AUTHORIZATION AND CONSENT.**

\_\_\_\_\_  
Patient/Legal Guardian Signature                      Date                      Witness                      Date

\_\_\_\_\_  
Person signing on patient's behalf/relationship                      Reason patient is unable to sign

\_\_\_\_\_  
Physician                      Date