

INFORMED CONSENT FOR INJECTION THERAPIES

I, _____,
have been informed by my practitioner that all injection treatments are accompanied by possible risks. I understand that in all injection therapies there is commonly but not always: bruising, temporary increase in pain, inflammation and temporary numbness. There is also the possibility of infection, allergic reaction, numbness, weakness or paralysis, spinal headache from dural puncture, lung puncture, or death as a result of, or in relation to the injections.

I understand that injections may vary, depending on the problem or need. Injections may include nerve blocks, trigger blocks, intramuscular injections, scar injections (neural therapy), joint injections, tendon injections or ligament injections.

I understand that insurance reimbursement for injections varies and that injection therapies may be considered investigational or experimental by some carriers.

I give my permission for Dr. Phillips to give me injections as he feels they are needed. I acknowledge that I have been given the opportunity to discuss the nature and purpose of the treatment; alternate methods of treatment; and the risks, complications and consequences associated with the administration of injections. I further acknowledge that any questions I have regarding the procedure have been answered to my satisfaction and that I have been further told that any additional questions I may have will be answered.

I have read (or have had read to me) the above "consent". My practitioner has explained the procedure(s) to me so that I fully understand it (them). No guarantee of successful treatment has been implied.

DATE: _____

SIGNATURE: _____

If signed by representative, indicate relationship: _____