California Sports and Spine Institute, PC

Patient Name: ________________________ Patient DOB: _________________________
Patient ID: __________________________ Patient Phone Number: _________________

I hereby authorize **Dr. Maxim Moradian,** to perform the following operation/procedure:

____

UNDER FLUOROSCOPIC GUIDANCE (PROCEDURE TIME: MINS)

I also authorize any further procedure, which in his judgment, needs to be done because of any unforeseen condition, which arises during the procedure.

Risks and complications of the procedure above have been fully explained and include, but are not limited to the following:

*Perforation of dura resulting in a headache (rare), *Increased pain (common), *Infection (rare), *Nerve or spinal cord damage (rare), *Bowel or bladder dysfunction (rare), *Spinal block (possibly requiring intubation and hospital admission; rare), *Adverse reaction to anesthetic or other medication including allergic reactions, *Fluid retention, increase blood pressure, and/or increase your blood sugar levels (due to steroids, less rare)

I understand and accept that any of these complications could lead to further hospitalizations and surgical procedures for their correction, and although it is very rare (<0.1 %), in my death.

The nature and purpose of the operation/procedure, possible alternative methods of treatment, the special risks and consequences involved, the possibility of complications and the prognosis if no treatment is received have been explained to me.

I am aware that, in addition to the risks that have been described to me, there are other risks, such as loss of blood, infection, cardiac arrest, etc., that attend the performance of any operation/procedure. I am also aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed operation/procedure. Furthermore, I have been informed of the comparative risks, benefits and alternatives associated with performing the procedure in an ambulatory facility versus a hospital facility.

I have had sufficient opportunity to discuss my condition and treatment with my physician, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed operation/procedure.
I realize that unexpected conditions may arise during my operation/procedure, with which the physician may encounter, and I consent to additional procedures, which may be necessary to manage these conditions. I understand that my medical insurance my not cover transportation or emergency treatment at an alterative facility and/or subsequent hospitalization and surgery arising. I understand that I am solely responsible for any additional fees that may be incurred. I consent to the administration of such anesthetics as may be considered appropriate by the physicians responsible for this service. For the purpose of advancing medical education and knowledge, I consent to the admittance of qualified observers to the operating room. Additionally, I consent to

the use of photographs and other materials for teaching, scientific purposes and presentation to conferences nationally.

I understand that steroids have not been FDA approved for the use of epidurals, but they typically are used in these procedures for pain.

I consent to the disposal, by the facility, of any tissue or body parts or foreign bodies that may be removed as a necessary part of my/the patient's care.

Understanding all of the above, I intend to be legally bound by this informed consent that I am signing voluntarily after it has been completed and after I have had the opportunity to read and fully understand it. I hereby authorize the performance of the above-noted operation/procedure.

I have received and understand the verbal and written pre-procedure instructions.

____
Signature of Patient/Legal Guardian

DATE: ____/____/_____ Time: ____/_____/_____AM/PM

WITNESS'S CERTIFICATION

- ☐ The Patient / Legal Guardian has read this form or had it read to him/her.
- ☐ The Patient / Legal Guardian states that he/she understands this form.
- ☐ The Patient / Legal Guardian has no further questions.

DATE _____/_____/____ Time: ____/_____/_____AM/PM

____
Signature of Witness

PHYSICIAN'S CERTIFICATION

I hereby certify I have discussed and explained the operation/procedure and answered any questions referring to the operation/procedure in this consent with the individual granting consent.

________________________________	____/____/____	____/_____/_____AM/PM
Physician's Signature	Date	Time