REBALANCE
SPORTS MEDICINE

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# INFORMED CONSENT FOR OTHER PROCEDURES

**PLEASE READ CAREFULLY**

**PATIENT NAME:** ______________________________________________________________

1. I, _______________________________________________, (patient or guardian) authorize

Dr. ____________________________________________ and any assistant(s) he/she deems

necessary to perform the following procedure:____________________________________________

2. I understand that the procedure involves the following: ___________________________________

_______________________________________________________________________________

3. RISKS: Possible complications of this procedure include, but are not limited to bleeding, scarring and/or other cosmetic changes, and infection.

4. Anaesthesia: The administration of local anaesthesia or pain relief medications that may be administered also involves serious risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such anaesthetics and medications as may be considered necessary by the person responsible for performing this procedure, except:

_______________________________________________________________________________

5. Results not Guaranteed: I understand that no guarantee or assurance has been made to me as to the results of the procedure and that it may not cure the condition. Alternatives are:

_______________________________________________________________________________

6. I have read and fully understand this consent form, and understand that I should not sign this form if all items, including my questions, have not been answered to my satisfaction or if I do not understand any of the terms of words contained in this consent form. IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, OR QUESTIONS CONCERNING THE PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PROVIDER NOW, BEFORE SIGNING THIS FORM. DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTOOD THIS FORM.

| ________________________ | ____________________ | _______________ |
|---|---|---|
| Patient/Guardian Signature | Patient Name (print) | Date & Time |

7. PROVIDER DECLARATION I have explained the contents of the document to the patient and have answered all the patient's questions. To the best of my knowledge, I feel the patient has been adequately informed and has consented.

| ________________________ | ____________________ | _______________ |
|---|---|---|
| Provider Signature | Provider Name (print) | Date & Time |