PAIN MANAGEMENT℠
SPECIALISTS
at Medical Center Clinic

Pain Management Treatment Consent

The following information is meant to help clarify your understanding of, and aid you in, giving consent for your procedure with my pain management physician.

1. The nature and purpose of the treatment plan, possible alternative treatments, risks, and possible complications will be explained to you by the physician. Assure that all questions and concerns are addressed prior to any procedures.
2. I understand that during the course of my treatment unforeseen conditions may necessitate an extension of my original treatment plan. I, therefore, authorize my physician or his/her designee to perform such treatments as deemed necessary in the exercise of his/her professional judgment.
3. I consent to the admittance and involvement of qualified personnel, such as doctors, nurses or technicians, for the purpose of medical education as deemed necessary by the physician.
4. I consent to be tested for AIDS (HIV infection) only in the event a healthcare worker receives my blood or body fluids to an open wound or his/her mucous membranes or receives a needle stick during the course of my treatments at Medical Center Clinic.

I confirm by my signature that I have read and fully understand the above Pain Management Treatment Consent.

_____	_____	_____
(Patient Signature)	(Patient Printed Name)	(Date)

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