Dr. Bruce H. Levin
Interventional Pain Management
Board & Subspecialty Board Certified

1. I consent Dr. Bruce Levin, MD or another doctor he may designate to perform upon me the following operation, procedure and/or medical treatment with or without Fluroscopic, Ultrasound, CT, or MRI guidance:

Cervical Thoracic Lumbar Facet injections of steroid and local anesthetic
Levels:

Cervical Thoracic Lumbar Transforaminal epidural injections of steroid and local anesthetic.
Levels:

Other:

2. The information listed below has been explained to me about the operation, procedure and/or medical treatment.

The nature and extent of the operation, procedure and/or treatment.

• Other types of treatment I could choose and what may happen if I do not have treatment.

• Possible complications include, but are not limited to:

Death, infection, headache, drug or other allergic or adverse reactions to steroids or local anesthetic effects, respiratory arrest, heart attack, abscess, collapsed lung, organ perforation, stroke, seizure, paralysis, weakness, nerve damage, new or increased pain or worsening of symptoms, bleeding, blood clot, blood vessel damage, occlusion or dissection, disability, exacerbation of other medical conditions, spinal cord injury, total spinal, vegetative state, fetal damage or death if pregnant.

The information was provided to me in terms that I understand. I am aware that the practice of medicine is not an exact science. I agree that no guarantee of results, success or cure has been given to me.

If, in the opinion of my doctor, any conditions are found in the course of the treatment which require additional or different treatment than those listed above, I allow my doctor to perform such procedures.

3. If I am prescribed an opioid or other medication, I understand it is my obligation to take them as directed. I understand that all treating physicians are to be made aware that I am receiving these medications and that I will not receive these medications from another physician. I

understand that I will be required to undergo random urine drug screens. It is my understanding that failure of these points will result in my discharge from the practice.

4. I understand that my doctors or others may need to administer conscious sedation injections and/or nerve blocks. If so, the possible complications of the type of planned anesthesia have been explained to me.

5. I consent to the taking and publication of any videographic or photographic reports in the course of treatment for inclusion in my medical record for treatment, education or other purposes.

6. I consent to the release of my Social Security number to the manufacturer of any surgical implants.

7. I understand that I can change my mind any time before this procedure and withdraw my consent in whole or in part by indicating on this form.

8. I understand that my doctor and those doctors that care for me in a hospital or outpatient facility may not be employees of agent of that facility. I will receive a separate bill for their services.

9. I certify that I read this consent form or it has been read to me. I understand the information in this form, and all of my questions were answered to my satisfaction.

_____ _____

Date/Time Signature of Patient/Authorized Representative and Relationship

_____ _____ _____

Date/Time Witness to Signature Second Witness (if verbal consent)

I have explained the narue of the above treatment as well as reasonalb anticipated risks, complications, and alternative to such treatment.

_____ _____

Date/Time Signature of Physician

I certify that I have had the above referenced procedures at the levels noted and have received and understood all postoperative instructions given to me.

_____ _____

Date/Time Signature of Patient/Authorized Representative and Relationship