NorthStar Rehab + Pain Clinics

Informed Consent for Procedure

Your physician has explained the details of the procedure listed below.
I authorize ANJUM S. KHAN, M.D. to perform the following procedure(s) under fluoroscopy:

Initial next to your procedure:

_______ Cervical/Thoracic Facet Injections

________ Lumbar epidural steroid injection(s)/Caudal Epidural Injection

________ Lumbar medial branch blocks

________ Lumbar/Sacral Facet Injections

________ Sacroiliac joint injection(s)

________ Peripheral nerve block(s) [ ] shoulder [ ] knee [ ] hip

________ Occipital Nerve Block

________ Other: ___________________________________

_____ Initial **X-ray consent:**
I certify that I am consenting to X-ray/fluoroscopy: I have been informed of the risks if I am pregnant or could be pregnant, there are potential adverse effects to me and/or my embryo fetus and benefits associated with this x-ray procedure during pregnancy.

_____ Initial **Use of images consent:**
I certify that X-ray/fluoroscopy images of my procedure may be used in conjunction with educational endeavors or promotional marketing of the procedure.

_____ Initial **Procedure consent:**
I certify the first page of this form, which has been provided for my personal records, has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I understand there are risks involved with the surgery, to include rare complications, even death, which may not have been specifically mentioned above. The risks have been explained to my satisfaction and I accept them and consent to this procedure. I am aware of alternative treatments.

_____ Initial **Cancellation fee consent:**
I certify that I will be responsible for a $50 cancellation fee if I fail to cancel within 5 business days of my surgery.

Signature of Patient or Legal Representative:____

Printed Name of Patient or Legal Representative: ________________________________ **Date:** _____________

Physician Name: Anjum S. Khan, MD **Signature of Physician:** _____________________________________

If signed by person other than the adult patient, relationship to patient: ___________________________________