Procedure Consent

Date: _____

I authorize the performance on (name of patient): _____

of the following operation and/or procedure _____

to be performed by or under the direction of Traci A. Purath, M.D. together with associates or assistants of her choice who may be employed by Diamond Headache Clinic Purath Headache & Neurology.

The provider has discussed with me and I understand the following items:

A. The nature and purpose of the proposed procedure(s)

B. The risks of the proposed procedure(s)

C. The possible or likely consequences of the proposed procedure(s)

D. All feasible or alternative treatments (including the risks, consequences, and probable effectiveness)

I consent to the performance of operation(s) and/or procedure(s) in addition to or those different from those now contemplated, arising from presently unforeseen conditions, which Traci A. Purath, M.D. or her associates or assistants may consider necessary or advisable in emergency or life-threatening situations.

I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

I have read and fully understand this entire form. I have asked the physician any questions I may have had, and the physician has answered any questions I asked to my satisfaction.

Patient Name: _____ Patient DOB: _____

Signature (Patient/Guardian): _____ Time: _____ Date:_____

Witness Name:_____ Witness Signature: _____

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