

Miguel Pupiales, M.D.

Consent To
Surgical, Therapeutic, or Diagnostic Procedures

I hereby authorize Dr MIGUEL PUPIALES as my physician and such associates, technical assistants and other health care providers as he or she may deem necessary to perform the following procedure(s).

Date of Procedure _____ Time _____

I understand that other staff physicians, physician assistants and/or nurse practitioners may participate in the procedure under the supervision of my physician(s).

I have had explained to me the nature of my condition, the procedure(s) to be performed, the nature and probability of the risks involved, the benefits to be reasonably expected, the impossibility of prediction results, the likely result of no treatment, and any alternative treatments and their risks and benefits.

I also realize that the following risks and hazards may occur in connection with this particular procedure: bleeding, infection, pain at the site of injection, low or high blood pressure, numbness arm(s) or leg(s), paralysis, visual disturbances, gastrointestinal disturbances, neural or spine cord injury, recurrence or persistence of the condition(s) that necessitated the procedure, increased, continued, different pain, elevation of blood sugar levels, decreased resistance to infection, impaired muscle function, seizure, coma or death.

I understand that my physician may discover other or different conditions that require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures that are advisable in their professional judgment.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

Patient/Other Legally Responsible Person Signature _____

Patient/Other Legally Responsible Person Name (Print) _____

Witness: _____ Dr. Signature: _____

Date: _____