Thank you for choosing spineTECH.
We shall do our best to provide you with quality and courteous care of your neurological needs.

General Consent for Care & Treatment

You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point, no specific treatment plan has been recommended. This consent form is simply to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any conditions.

This consent provides us with permission to perform reasonable & necessary medical examinations, testing, and treatment. By signing you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and you consent to treatment at this office or another office under common ownership. The consent will remain effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered. If you have any concerns regarding any test or treatment recommended, we encourage you to ask questions.

I voluntarily request a physician, mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), other healthcare providers, designees as a necessary, to perform reasonable and necessary medical examination, testing, treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures.

*I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Representative: _____ Date: _____

Patient Name: _____