Peripheral Neuropathy-CET Permit Consent Form

1. Written Consent: Consent to do procedure, anesthetics, and other medical services for Peripheral Neuropathy.
2. I, _____authorize the performance for the following procedure(s): Low dose peripheral nerve blocks followed by specific parameter electro-analgesia treatment of the lower extremities to be performed by or under the direction of the physician and or his/her associates or assistants.
3. I consent to the performance of procedures in addition to or different from those completed, whether or not arising from presently unforeseen conditions, which the above named doctor or his associates or assistants may consider necessary or advisable in the course of this particular procedure.
4. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for the service including additional or subsequent similar future procedures as indicated.
5. I consent to the photographing or television of the procedures to be performed, including appropriate portions of my body for medical, scientific or educational purposes.
6. For the purpose of advancing medical education, I consent to the admittance of observers to the procedure room.
7. The nature and purpose of my diagnosis, condition, recommended procedure, risks involved, benefits, alternative methods of treatment, the possible consequences, and the possibility of complications have been explained to me by the physician and or his/her associates or assistants. I further acknowledge that the procedure is an elective, non-emergency type of therapy/procedure and that I have thought over all the information that the physician and staff has given me.
8. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained. Although an excellent result is expected, the possibility of complications could arise. They may or could include although not limited to:

9.

A. Swelling	B. Bleeding	C. Extended discomfort	D. Infection
E. Injury	F. Delayed healing	G. Condition no better	H. Medication reaction
I. Numbness	J. Blood clot	K. Joint stiffness	L. Excessive bleeding

10. I also acknowledge that it has been explained and discussed with me, by DFW Neuropathy's associates and/or assistants, that the treatment may result in some numbness and effect the full use of the treated extremity following treatment; and that his may impair my ability to operate a motor vehicle or heavy machinery. I agree that until I understand and evaluate my abilities following each treatment I will reframe from driving a motor vehicle or operating heavy equipment, and/or I will seek assistance for such activities.
11. I also understand that DFW Neuropathy specializes in the treatment of Peripheral Neuropathy as a sub-specialty practice, but does not provide primary care services, and therefore I must continue to follow up with my PCP, and other specialists for all my medical conditions and co-morbidities including the overall health care of my extremities and seeing my PCP more often or an orthopedic, rheumatologic, or podiatric specialist as necessary.
12. The above has been explained to me in non-medical terms that I understand, and I acknowledge that all the underlined spaces on this document have been completed and explained to me prior to signing.

_____ _____

Patient signature Date

_____ _____

Physician signature Date