Acknowledgement of Fee's

You have elected to have a nonsurgical interventional procedure performed at a local Hospital or Ambulatory Center. There are 3 components of fee's associated with having any type of procedure. They are as follows:

The Insurance re-imburses for the surgery center's expenses
The insurance re-imburses the physician for the services provided
Any remaining costs that the insurance does not pay to the provider which the patient is directly responsible for.

This is in ADDITION to any co-pays that are collected for the procedures. Lastly there may be remaining costs that the patient may be responsible for paying directly to the surgery center if their insurance does not cover all costs.

By signing below, you acknowledge that a staff member from Dr. Munshi has had you read over this agreement and that you fully understand the above listed terms and conditions.

_____
Patient's Name

_____ Date: _____
Patient's Signature

Munshi Modern Pain
12553 Gulf Freeway, Houston, TX 77034
PHONE: 281-481-8557
FAX: 281-481-8540

Authorization and Informed consent for Outpatient Procedure

***SIGN ONLY AFTER READING THIS ENTIRE DOCUMENT AND FULLY UNDERSTAND ITS CONTENTS**

NAME: _____ DATE:_____ AGE:_____ SEX: M F

PROCEDURE: CERVICAL ESI THORACIC ESI LUMBAR ESI CAUDAL ESI

FACET JOINT SI JOINT DISCOGRAM

PAIN PUMP REFILL

SYMPATHETIC NERVE INJECTION

SPINAL CORD STIMULATOR

RADIOFREQUENCY ABLATION

COOLED RADIOFREQUENCY ABLATION

PATIENT HISTORY:

YES	NO	
		DIABETS/METABOLIC SYNDROME
		*CURRENT OR RECURRENT INFECTIONS If yes please inform Dr. Munshi right away
		PHLEBITIS/HISTORY OF BLOOD CLOTS
		ARE YOU PREGNANT OR POSSIBLY PREGNANT? IF YES: YOU ARE NOT ELIGIBLE FOR THE PROCEDURE. Please do not proceed filling out this form and return to the front desk.
		*ARE YOU ON A BLOOD THINNER? IF YES PLEASE NOTE WHICH MEDICATION AND PLEASE NOTE THAT MOST BLOOD THINNING MEDICATIONS ARE REQUIRED TO BE STOPPED PRIOR TO YOUR PROCEDURE BY UP TO 14 DAYS. PLEASE CALL THE CLINIC TO FIND OUT THE EXACT AMOUNT OF TIME YOUR MEDICATION NEEDS TO BE HELD.

I ACKNOWLEDGE THAT MY PROCEDURE HAS BEEN EXPLAINED TO ME IN DETAIL AND IN LAYMANS TERMS WHICH ARE UNDERSTANDABLE TO ME.

The purpose of the procedure is to decrease pain, repair the injury, and promote healing. Every procedure has a risk associated. Patients should consult Dr. Munshi to determine risk vs. advantage of the procedure. The material risks associated with this procedure or treatment may include but are not limited to the following:

Soreness, allergic reaction, infection, numbness, tingling, paralysis/partial, partial loss of limb function or organ injury, severe blood loss, pneumothorax, scaring, depigmentation, cardiac arrest, brain damage, mental status changes, disorientation, sensory disturbance, insomnia, mood swings, euphoria, depression, facial warmth, fluid retention, hypertension, hypotension, hyperglycemia, headaches, gastritis, menstrual irregularities, nausea, rash, fever, dizziness, Severe Headaches from dural puncture leading to spinal fluid leakage, fistula, abscess, hematoma, avascular necrosis, skin necrosis, possible birth defects for pregnant females, seizures, change in pain level. If some of these reactions occur there is the possibility of death.

If you suffer from a side effect call the clinic. For severe headaches call the clinic immediately or go to the hospital right away. For other major side effects/injuries call 911.

Dr. Munshi will discuss your overall results of the procedure with you at your office follow up. There is no level of guarantee that any given procedure will work. Medicine is not an exact science. Please write down any questions for him and discuss it at your follow up.

I understand that during the course of the procedure or treatment it may be necessary or appropriate to perform additional procedures or treatments that are unforeseen or not known to be needed ahead of time. It may also be necessary or appropriate to have diagnostic studies, tests, anesthesia, x-rays, and other procedures during the course of your treatment. I consent to authorize Dr. Munshi to perform such additional tests and or procedures as they deem necessary or appropriate.

In an Emergency situation you authorize Dr. Munshi and his surgical staff to execute emergency protocol when needed.

Patient is to understand that any body tissue or fluids that are removed during the procedure will be discarded by the institutions policy for biohazard waste.

AT HOME CARE POST PROCEDURE:

Rest, heat therapy, relaxation. Pain post procedure is typically mild in nature and usually will resolve within 3 days. Allowable medications should be taken to help with any soreness or pain associated. If pain is severe or minor pain lasts for more than 3 days call the clinic.

I understand that if I don't show up for my procedure without giving the office a 24 hour heads up that there may be additional "no show" fee which the patient will be responsible for paying. Any payments made towards a procedure will not be returned. Patient will receive a credit towards their balance.

I HEREBY VOLUNTARILY REQUEST TO PROCEED WITH THE PROCEDURE FULLY UNDERSTANDING THE PROCEDURE ITSELF AND THE POSSIBLE RISKS OF THE PROCEDURE. I READ THROUGH THE ENTIRE DOCUMENT AND ATTEST THAT THE TERMS LISTED ARE FULLY UNDERSTANDABLE. I ATTEST THAT I AM NOT PREGNANT OR BREASTFEEDING IF APPLICABLE. I ATTEST THAT I HAVE UPDATED ALL MY MEDICATIONS WITH THE OFFICE AND HAVE MADE SURE TO INFORM DR. MUNSHI IF I AM ON A BLOOD THINNER AT LEAST 2 WEEKS PRIOR TO THE PROCEDURE.

PATIENT'S NAME:_____ DATE:_____

SIGNATURE:_____

OR NAME AND SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE

NAME:_____ SIGNATURE:_____

DATE:_____

OFFICE STAFF CONFIRMATION:

NAME: _____SIGNATURE:_____ DATE:_____

Munshi Modern Pain
12553 Gulf Freeway, Houston, TX 77034
PHONE: 281-481-8557
FAX: 281-481-8540