ADVANTIA HEALTH

Informed Consent for Medical and/or Surgical Procedures

Virginia state law guarantees that you have both the right and obligation to make decisions concerning your health care. Your doctor can provide you with the necessary information, but as a member of your personal health care team, you must help make the decision. This form has been designed to show that you agree with the surgery/procedure and treatment recommended by your doctor.

Details of Procedure:

A. **Consent:** I authorize and voluntarily request **Eric S. Chang, MD** as my physician and other persons (Such as colleagues, physicians-in-training, technical assistants, and other health care providers as my physician may select), to treat (including further diagnosis of) my condition.

B. **Procedure/Surgery:** I understand that the surgical, medical, and/or diagnostic procedure(s) listed below are planned for me to treat the following condition: **Percutaneous Tibial Nerve Stimulation (PTNS)**

C. **Risks:** While not getting treatment as risks, I realize that the Procedure(s) planned for me also have risks. I understand that complications of the Procedure(s) could require corrective surgery and/or other procedures. I understand the risks associated with the proposed Procedure(s), including but not limited to those listed below and have had the opportunity to ask questions about the risks:

- Infection
- Bleeding/Hematoma
- Pain
- Allergic Reaction
- Separation of the wound
- Blood vessel and/or nerve injury
- Worsening and/or recurrence of symptoms
- Injury to other tissue, blood vessels, nervous system and/or organs affected by the process of my intended Procedure(s)
- Other _____

D. **Extension of Consent:** I understand that in the course of performing the above Procedure(s), my physician may discover other or different conditions which may require additional or different Procedure(s) than those planned. I authorize my physician and his/her associates, designees, physicians-in-training, technical assistants and other health care providers to perform other Procedure(s) which they deem necessary and advisable in their professional judgment.

E. **No Guarantee:** I understand that the practice of medicine and surgery are not exact sciences and I acknowledge that no warranty or guarantee has been made to me about the result of the Procedure(s).

F. **Photography:** I authorize the photographs, videotaping, digital imaging audio tapings, filming, recordings and other visual and audio means may be taken of my procedure(s) for the purpose of my treatment, identification, or diagnosis.

Patient Consent:

I am legally competent and have sufficient knowledge to give this voluntary and informed consent. I have read and fully understand the consent form.

_____ _____ _____

Patient Signature/Health Surrogate | Relationship | Date

_____

Witness Signature

Physician certification: I HEREBY CERTIFY that I have provided and explained the information set forth herein and answered all questions of the Patient or the Patient's Representative, concerning the Medical Treatment or Surgical Procedure to the best of my knowledge and ability.

_____ _____

Signature of Physician | Date/Time

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