WAYNE NEUROLOGY, PLC

34815 W Michigan Ave. Wayne MI 48184 Tel: 734-721-4739 Fax: 734-725-3184

Consent to Medical/Surgical Procedures

I (or my authorized representative), _____ DOB_____

consent to the procedures outlined below to be performed by _____

Today I received _____ for the diagnosis/treatment of:

_____

_____

The procedure has been explained to me in terms that I understand; The explanation included but not limited to:

_____

- The nature and extent of the procedure to be performed
- General risks which may include pain, scarring, bleeding, and infection
- Benefits of the procedure
- Risk and benefits of any reasonable alternatives to this procedure including having no treatment at all

I was given the opportunity to ask any question I have regarding the procedure, and I have had those questions answered to my satisfaction.

I understand that I have the right to refuse any medical/surgical treatment recommended at anytime prior to its performance.

I authorize the physician or his/her staff, associate, or assistant to whom the physician may assign the responsibility to performing the procedure.

I acknowledge that I have read (or had read to me) and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits, and alternatives have been explained to my satisfaction. I hereby authorize my physician to perform the above discussed procedure.

_____ _____

Patients Signature/Power of Attorney/Guardian Date

I verify that I have explained the information contained in this document to the patient or person giving consent. It is my opinion that the person greeting consent has fully understood all subjects discussed.

_____ _____

Physician Signature Date