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Neurosurgical Spine Institute

CONSENT FOR TREATMENT:

I, ______________________________ give permission to Neurosurgical Spine Institute and its associated physicians, clinicians and other personnel to provide medical treatment and diagnostic procedures. I, ____________________ consent of lab testing that Neurosurgical Spine Institute orders. I am aware that my physician, Dr. Marat Grigorov is available to answer questions about my treatment or about this form.

Dr. Grigorov has educated me regarding medication that has been prescribed to me:

1. The specific condition to be treated
2. Possible side effects
3. If surgical intervention all risk and benefits have been discussed

I have been given the opportunity to ask questions and consent is given voluntarily. I understand that I have the right to withdraw consent for this treatment at any time, after consulting with the prescribing provider.

Client/Guardian printed name and signature:

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PRINTED NAME

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SIGNATURE DATE