Authorization for & Consent to Special Diagnostic or Biopsy Procedures

Name _____ **Date of Birth** _____

Referring Physician _____

Back Bay Physician _____

Procedure _____

1. Back Bay Imaging maintains personnel and equipment to assist your physicians in their performances of various diagnostic procedures. These procedures may all involve risks of unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to the result or cure.

   You have the right to be informed as to the risks as well as the nature of the procedure, the expected benefits or effects of such procedure and the available alternative methods of treatment and their risks and benefits.

2. Your physician(s) has recommended the procedure set forth above. Upon your authorization and consent, the procedure will be performed by the radiologist named above, (or in the event of any situation causing his or her inability to complete the procedure, a qualified substitute radiologist) together with the technologist and assistants and possibly a pathologist from DISC Sports & Spine Center.

3. After explaining the procedure, the area of interest will be cleaned, when applicable the radiologist will use a numbing agent prior to inserting the needle or making an incision. The procedure will then be performed with instructions for post procedure care given to you at the end of the procedure.

4. ALLERGIES, BLEEDING PROBLEMS, MEDICATIONS, OTHER MEDICAL CONDITIONS: You must notify the radiologist and technologist performing this procedure if you have any allergies, if you have a history of adverse reaction to medication, if you have a history of heart disease, kidney disease, diabetes, asthma, tend to bleed easily when cut, have high blood pressure or other serious medical conditions. Also please inform us if you have been on any aspirin or blood thinning medications within the last 7(seven) days.

YOUR SIGNATURE ON THIS FORM INDICATES: (1) that you have read and understand the information provided in this form, (2) that you have been verbally informed about this procedure by the physician and technologist, (3) that you have had a chance to ask questions (4) that you have received all of the information you desire concerning the procedure and (5) that you authorize and consent to the performance of the procedure.

PATIENT NAME: _____ **DATE:** _____

_____ _____

SIGNATURE* WITNESS

*Patient or Patient Representative: Parent/Conservator/Guardian