The Dungy Orthopedic Center
2121 West Chandler Boulevard
Suite 110
Chandler, AZ 85224

Patient Informed Consent for an Injection

I, _____, (patient or guardian) authorize Danton S. Dungy MD to perform an injection.

OPTIONS
Danton S. Dungy, MD has discussed with you the other treatment options available for your specific problem which may include, but are not necessarily limited to: behavior modification, assistive devices (i.e. braces), physical therapy, medication, and surgery.

BENEFITS
The goal of the injection is to help you regain a more active lifestyle by reducing your pain. The length of pain relief will vary based on your individual response.

CAUTION
Do not proceed with an injection and notify the doctor if you are allergic to local anesthetic. The safety in women who are pregnant or breast-feeding has not been tested by the Food and Drug Administration.

THE TREATMENT YOU ARE AGREEING TO RECEIVE IS:
Cortisone injection (also called a steroid shot) in:

R **L** **BILAT** Location:_____

RISKS
There is a possibility of elevated blood sugars, infections, and skin changes (thinning or discoloration). This injection may cause some swelling and pain.

CONSENT
I have read and fully understand this consent form. I understand that I should NOT sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any term or word contained in this consent form. I have no further questions.

_____ _____
Patient/ Guardian Signature Date

I have explained the contents of this document to the patient and have answered all of his/ her questions to the best of my ability. The patient has given consent and is ready to proceed.

_____ _____
Provider's Signature Date

Advanced Beneficiary Notice

Although patients may benefit from the evaluations and treatments outlined by medical providers, commercial insurances and/or Medicare may not cover these services. Some insurers are not covering office visits in combination with administering injections during the same visit. As a result, medical providers are not compensated for the full scope of patient evaluations and interventions.

Once our health care professional administers your injection, we will directly bill your insurance. However, if your insurance does not cover the service(s) provided, you will be financially responsible for any balances accrued. The balance will be due immediately.

By signing this notification, you agree to the outlined treatment discussed with your provider and you assume financial responsibility for the service(s) rendered, if not fully covered by your insurer.

**For safety reasons, we will not accept or administer medications brought in by patients. We will only administer medication that has maintained a medical chain of custody. This means the medication must be provided directly from the supplier (pharmacy, specialty, insurer, etc.).

_____ _____

Patient/ Guardian Signature Date