



## Charleston Pain and Rehabilitation

### INFORMED CONSENT TO PROCEDURE

I authorize Jeffrey W. Buncher, M.D. to perform any of the following procedures:

I authorize Jessica Walters, MS, PT to perform any of the following procedures:

I authorize Alex Torres, L. Ac., Dipl. O.M. to perform any of the following procedures:

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**MEDICATION:** Any drug can cause headaches, nausea, stomach pains, dizziness, nervousness, and other side effects, including but not limited to allergic reactions, coma and/or death.

**PHYSIOTHERAPY** (hot/cold therapy, electrical therapies, and ultrasound): Complication may include but limited to skin irritation, nerve or muscle injury.

**TRIGGER POINT INJECTIONS:** Complications may include but not limited to pain, swelling, skin irritation, spasm, infection, nerve or muscle damage, allergic reaction, pneumothorax, coma and/or death.

**NERVE BLOCK:** Complications may include but not limited to injury to the area, numbness, pain, swelling, skin irritation, nerve or muscle damage, spasm, infection, prolonged anesthesia, paralysis, allergic reactions, coma and/or death.

**EPIDURAL:** Complications may include but not limited to injury to the area involved, prolonged anesthesia, pain, swelling, skin irritation, nerve damage/irritation, allergic reaction, paralysis, spasm, coma and/or death.

**MANIPULATION OF THE SPINE:** Complications may include but not limited to the rib fracture, disc injury, nerve damage, increased pain, stroke and death.

**ACUPUNCTURE:** Complications may include but not limited to injury to the area involved, pain, swelling, skin irritation, infection, nerve damage irritation, paralysis, spasm, coma, and/or death.

I do not have any past illness, injuries, or other pertinent conditions of which I have not informed the doctors about other than:\_\_\_\_\_.

If any foreseen condition arises on the course of this procedure calling in his/her judgment for procedures in addition to or different from these initially contemplated. I further request and authorize him/her to do whatever he/she deems advisable.

The nature of this procedure has been explained to me. I acknowledge that no guarantee has been made as to results that may be obtained. I acknowledge that I have read and understand the above consent for this procedure.

I, \_\_\_\_\_ have been informed of the risk and possible complications of the treatments recommended to me by the above doctors. I also understand that there may be other treatments and doctors who may be able to help and I am welcomed to seek out such care.

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Patient \_\_\_\_\_ Date \_\_\_\_\_

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Witness \_\_\_\_\_ Date \_\_\_\_\_

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Physician \_\_\_\_\_ Date \_\_\_\_\_