Lifecare Primary Medical Associates, PLLC

633 E Fernhurst Dr. Suite 202. Katy, TX-77450, Tel: 281-712-7757, Fax: 281-712-7758

MEDICAL AND SURGICAL PROCEDURE DISCLOSURE AND CONSENT FORM

PATIENT NAME: _____ D.O.B:_____

To the patient: You have the right as a patient to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used. You may make the decision whether you will undergo the procedure after knowing the risk and hazards involved. We strive to inform and make you understand your right to withhold your consent to the procedure.

I fully understand the risks and hazards involved. I give my full consent and authorize Sohail R. Siddiqui, M.D, P.A to authorize associates as they may deem necessary to treat my condition which has been explained to me.

PAIN STEROID INJ: (LEFT) (RIGHT) KNEE-SHOULDER-SI JOINT-WRIST-BACK-OTHER:_____

ULTRA SOUND GUIDED INJECTION: YES/NO

SKIN TAG REMOVAL: _____ SITE: _____

INFLUENZA/ZONE: LOT:_____ EXP DATE:_____ NDC:_____

B12: 1CC LOT: _____ EXP DATE: _____ NDC:_____

DEXAMETHASONE: 4MG/8MG

LOT:_____ EXP DATE:_____ NDC:_____

ROCEPHIN: 500MG/1G

LOT:_____ EXP DATE:_____ NDC:_____

TORADOL: 30MG/60MG

LOT:_____ EXP DATE:_____ NDC:_____

KENALOG:40MG/80MG

LOT:_____ EXP DATE:_____ NDC:_____

1% LIDOCAINE: 1CC/2CC/3CC/4CC

LOT:_____ EXP DATE:_____ NDC: _____

OTHER:_____

I understand there is no warranty or guarantee has been made to me as the result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the procedure as mentioned above. I fully understand that the following condition may occur after this procedure: Pain, infection, bleeding, re-occurrence of condition, damage to joints, itching, and skin burns/blistering/rash etc. I certify this has been fully explained to me and that I have read or have had it read to me and that I understand its contents.

Signature:_____ Date:_____ Witness:_____