SPINE INSTITUTE
OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

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Patient Consent to Treatment

PURPOSE: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy. This disclosure is not intended to alarm or frighten you, but rather make you better informed so that you may give or withhold your consent to the proposed treatment.

CONSENT TO TREATMENT: I voluntarily request Dr. Okafor as my physician and such associates, assistants, nurses, and other health care providers as he may deem necessary or advisable to treat my condition. I understand that it is my responsibility to actively participate in my care in order to maximize improvement in my condition.

I understand that I may undergo extensive diagnostic tests and examinations during my treatment at the Spine Institute of Central Florida. If I am unable or unwilling to undergo such testing, my treatment plan may be revised and my outcome may be affected. During the course of treatment, I may be required to make frequent follow-up visits to review diagnostic and therapeutic test results. Accommodations for patients traveling significant distances will be made as much as possible, but patients will be required to personally attend office visits for appropriate care and treatment of their condition.

I agree to keep my physician and authorized associate(s) apprised of any changes in my medical condition. Certain diagnostic tests, treatments, and drug therapies can be dangerous under certain medical conditions or medication use. Pregnancy is one such medical consideration and females must be certain to acknowledge this condition prior to diagnostic imaging and initiation of any medication therapy. Female patients who become pregnant during the course of their treatment at the Spine Institute of Central Florida will need to notify their physician.

I understand that treatment of my condition will be directed initially toward conservative management in an effort to avoid surgical intervention, unless I have a condition that medically requires surgery without conservative management. Also, failing conservative care, I may then be considered a potential surgical candidate.

This Consent was signed by: _____
Printed Name – Patient or Representative

_____ ____/____/____
Signature Date

_____
Relationship to Patient (if other than patient)

Witness: _____
Name

_____ ____/____/____
Signature Date