Women's Health & Healing Center

INFORMED CONSENT FOR INJECTION THERAPY

I, _____ have been informed by Dr. Cheryl Hamilton and/or her staff that all injection treatments are accompanied by possible risks. I understand that in all injection therapies there is a possibility of bruising, temporary increase in pain, inflammation, infection, allergic reaction, numbness, weakness or paralysis, spinal headache, lung puncture, or death as a result of, or in relation to the injections.

I understand that injections may vary, depending on the problem or need. Injections may include nerve blocks, trigger blocks, intramuscular injections, scar (neural) therapy, joint injections, tendon injections, ligament injections or prolotherapy (also known as sclerotherpay or reconstructive therapy).

I understand that insurance reimbursement for injections varies and that prolotherapy, platelet rich plasma and neural prolotherapy may be considered investigational or experimental by some carriers and by Medicare.

I give my permission for Dr. Cheryl Hamilton to give me injections as she feels they are needed. I acknowledge that I have been given the opportunity to discuss the nature and purpose of the treatment; alternate methods of treatment; and the risks, complications and consequences associated with the administration of injections. I further acknowledge that any questions I have regarding the procedure have been answered to my satisfaction and that I have been further told that any additional questions I may have will be answered.

I HAVE READ (OR HAVE HAD READ TO ME) THE ABOVE CONSENT. DR. CHERYL HAMILTON HAS EXPLAINED THE PROCEDURE(S) TO ME SO THAT I FULLY UNDERSTAND IT (THEM). NO GUARANTEE OF SUCCESSFUL TREATMENT HAS BEEN IMPLIED. I UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS CONSENT FORM UPON REQUEST.

I understand that this procedure is usually not covered by insurance and I am responsible for the total charges.

_____	_____	_____
Patient Signature	Parent or Legal Guardian	Date
_____	_____	_____
Witness	Doctor	Date