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

Patient Informed Consent for an Injection

______, (patient or guardian) authorize Danton S. Dungy, MD/

| Tina M. Horton | ı, PA-C/ Travis | M. Tirk, PA-C to perfo | rm an injection. | | | |
|---|-----------------------------------|---|-----------------------------|--|------------------------|--|
| treatment opti | ons available fo | Horton, PA-C/ Travis r your specific proble stive devices (i.e. brac | m which may in | iclude, but are n | ot necessarily limited | |
| _ | • | nelp you regain a mor your individual respo | • | by reducing yo | ur pain. The length of | |
| from birds- fea women who ar | thers, eggs, or pre pregnant or b | on and notify the doc boultry. The Food and breast-feeding. AGREEING TO RECEI | Drug Administr | • | - | |
| □ Cortisone Injection | | | □ Hyaluronic Acid Injection | | | |
| (also called a steroid shot) | | | (also called gel injection) | | | |
| □ RIGHT | □ LEFT | □ BILATERAL | □ RIGHT | □ LEFT | □ BILATERAL | |
| | | | | <u>Medication</u> | | |
| | | | □ Synvisc | | \Box Orthovisc | |
| | | | □ Synvisc-01 | NE | \square Monovisc | |
| RISKS | | | □ Hyalgan | | □ Euflexxa | |
| There is a possibility of elevated blood sugars, | | | □ Supartz | | □ Gel-One | |
| infections, and skin changes (thinning or discoloration). This injection may cause some | | | □ Visco-3 | | □ GenVisc | |
| - | • | may cause some | RISKS | | | |
| swelling and pain. | | | | This injection may cause some pain and swelling. | | |
| | | | I III3 IIIJECUOI | i iiiay caust suii | ic pain and swelling. | |

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.

CONSENT

Updated August 8th, 2019

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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 |
|-----------------------------|--|--|
| | | |
| | | |
| | | |
| | | |
| | FOR OFFICE USE ONLY | |
| _ | s of this document to the patient and patient has given consent and is rea | have answered all of his/ her questions dy to proceed. |
| | | |
| Provider's Signature | | Date |
| Drug/ Lot #/Exp. Date | Drug/ Lot #/Exp. Date | Provider/M.A. Initials |