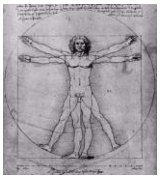

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Consent to Diagnostic and/or Therapeutic Procedure (s)

I, _____consent to, and authorize the following diagnostic, and/or therapeutic procedure (s) to be performed on myself _____
_____

The diagnostic and/or therapeutic procedure (s) is to include whatever interventions are required in attempting to accomplish such purpose. If any conditions are revealed at the time of the operation that were not recognized before and which call for procedures in addition to those originally contemplated, I authorize the performance of such procedures as well.

It is understood that the operation will be performed by **Dr. Axel Vargas** and whomever he may designate as his assistants. The nature and the purpose of the diagnostic, and/or therapeutic procedure (s) have been fully explained to me by my physician in lay man's terms, including the inherent risks and complications associated with the procedure, the risk vs. benefits ratio, real expectations and the potential side effects associated with this diagnostic, and/or therapeutic procedure (s). Also I was explained the risks related to alternative treatments, including the possible results of not receiving care, treatment, and services.

I further consent to the administration of anesthesia, as may be considered necessary or desirable in the judgment of my attending physician Dr. Axel Vargas.

I understand that the Dr. Axel Vargas will not honor any advance directive, and will perform any resuscitative measures deemed necessary. All questions with regard to Advance Directives have been answered to my satisfaction.

I consent to the admittance of observers to the operating room and examining room for the purpose of advancing medical education. Yes □ No □

I consent to the photographing or televising of the procedures to be performed, including appropriate portion of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or by the descriptive text accompanying them purpose of the operation, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me.

I have chosen this facility, under the guidance of my physician, as a convenient place for me to receive care. Each physician is a fully licensed physician in the State of Illinois and is governed by all the appropriate regulatory agencies. I understand that the River North Pain Management Consultants, S.C., does not employ any of the physician(s) and/or anesthesia personnel who provide anesthesia care in this facility. I understand that all of the physicians and anesthesia personnel who will provide care to me while I am in this facility are Independent Contractors are not under the control of River North Pain Management Consultants, S.C.

I CONSENT THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMED CONSENT TO THE DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURE (S) AND· THAT THE EXPLANATIONS REFERRED TO THEREIN WERE MADE.

_____

Signature of Patient or legally Authorized person Date Time

_____

Signature of Witness Date Time

_____

Signature of Physician Date Time