Informed Consent for Clinical Treatment

Patient Name:	
DOB:	**Provider:**

I, _____, hereby authorize Diamond Headache Clinic providers and staff to perform the following procedure(s) and/ or treatment(s) upon me, the patient.

Procedure(s)/ Treatment(s)

I understand that the procedure(s)/ treatment(s) appear to be indicated by the diagnosis and/ or clinical observations performed. I have been informed of the following:

- The nature of the proposed care, treatment, services, medications, interventions, or procedures.
- Potential benefits, risks, or side effects of the proposed care, treatment, services, medications, interventions, or procedures, the likelihood of achieving its goals, and the potential problems that may occur during recuperation.
- The likelihood of achieving care, treatment, and service goals.
- Reasonable alternatives to the proposed care, treatment, and service.
- If warranted, the relevant risks, benefits, and side effects related to the alternatives, including the possible results of not receiving care, treatment, and services.
- When indicated, any limitations on the confidentiality of information learned regarding the patient.
- This consent is voluntary.

I have informed the licensed health care provider that to my knowledge I have allergies to the following substances and/or medications (if none, please indicate N/A)

Allergies

- I acknowledge I have received no warranties or guarantees with respect to the benefits of the aforementioned procedure(s)/ treatments(s).
- I acknowledge that I have read and fully understand this document. If I have any questions, I have been given the opportunity to have them answered by the physician and/or health care provider.

CONSENTING PARTY	**WITNESS TO SIGNATURE**
Signature	**Signature**
Print Name	**Print Name**
Date	**Date**
IF CONSENTING PARTY IS OTHER THAN PATIENT OR UNDER THE AGE OF 18	
Signature	**Date**
Print Name	**Relationship**