

**STOCKDALE SURGERY CENTER**  
**9802 Stockdale Hwy Ste 104 Bakersfield Ca, 93311**  
**Phone (661) 665-7885 Fax (661) 735-3941**

**CONSENT FOR PROCEDURE**

I authorize Dr. Arturo Palencia/ Dr. Afaq Kazi and any associates or assistants of his choice to perform upon me the following procedure:

**Cervical Medial Branch Block with Fluoroscopy**

This procedure has been explained to me including its limitations, risks and complications (such as headache, bleeding, infections, and nerve damage, including paralysis and possible death). I understand that my pain may not go away completely. I realize that following my procedure admission to a hospital may be necessary.

I consent to the procedure proposed and administration of the necessary preoperative medications and local anesthetic. I realize that following the administration of medication or anesthesia, my mental alertness may be impaired for several hours.

Following the procedure, I will not drive myself home. I have made arrangements for a responsible adult to accompany me home.

I understand that there may be health care industry manufacturing representatives or other visitors present in the procedure room for the purpose of providing technical support during my procedure, and consent to this at the discretion and approval of the physician and office.

I understand that my medical records may be used for chart review by the office.

I understand that the office doesn't honor advanced directives. We will do everything possible to resuscitate you during the procedure.

\_\_\_\_\_  
Signature of Patient, Parent, or Legal Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

I certify that I have explained to the patient, to the extent reasonable and consistent with currently acceptable standards of practice, that need and nature of the named procedure(s), consequences and common complication, hoped for achievement and outcome, plus any pertinent alternatives to the procedure(s).

M.D. Signature & Date \_\_\_\_\_