INTERVENTIONAL RADIOLOGY, P.C.

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INFORMED CONSENT

I hereby request and authorize Interventional Radiology, PC and its staff (the "Practice") to perform upon me (the patient) the following operations(s), treatment(s) and/or procedure(s):

_____ (the "Procedure")

A. The Procedure has been explained to me and I have been provided with the necessary information for me to evaluate the risks and benefits of the proposed Procedure(s). I have also received information regarding: (a) the nature and purpose of the proposed Procedure and related care, treatment, services, medications, and interventions; (b) alternatives to the Procedure(s), as well as the relevant risks and benefits of such alternative procedure(s); (c) clinical outcome if I do not elect to have the proposed Procedure(s); (d) the potential benefits and possible risks, side effects and complications associated with the Procedure(s) including potential problems that might occur during recuperation; *and (e) the likelihood of achieving care, treatment and service goals. I understand that the Practice's Privacy Notice describes any limitations on the confidentiality of my patient information.*

B. It has been explained to me that during the course of the Procedure, unforeseen conditions may be revealed that necessitate an extension of the original Procedure(s) or the performance of different procedure(s). I authorize and request that the Practice perform such procedures as are necessary and/or desirable in the exercise of their professional judgment.

C. I acknowledge that no guarantees or assurances have been given to me by anyone as to the results that may be obtained from the Procedure.

I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

Patient/Agent/Guardian/Surrogate:

_____ _____
Signature Date Print Name

Relationship if signed by person other than patient:_____

PHYSICIAN'S CERTIFICATION

I hereby certify that I have explained to the patient (a) the nature and purpose of the proposed Procedure; (b) alternatives to the Procedure(s) and blood products as well as the relevant risks and benefits of such alternative Procedure(s); (c) clinical outcome if he/she does not elect to have the proposed Procedure(s); (d) the potential benefits and possible risks, side effects and complications associated with the Procedure(s), including potential problems that might occur during recuperation; and (e) the likelihood of achieving care, treatment and service goals. I believe that the patient/agent /guardian/surrogate understands what I have explained and answered. I hereby confirm the accuracy of the document including the description of the Procedure(s).

Physician _____ James Silberzweig, MD _____
Signature Print Name Date