

SpineMED™ Spinal Disc Decompression Informed Consent

I, _____, hereby give my consent for Spinal Disc Decompression on the SpineMED™ System and hold no responsibility, in any way, to Individual Physician/ Practitioner Name, Clinic Name and its staff members, as they are following the protocols of the SpineMED™ System set out in the guideline from the manufacturer of the SpineMED™ Table, CERT Health Sciences, LLC.

With respect to my decision to proceed with Spinal Disc Decompression, the Physician has:

- Informed me that from the clinical information available, I have no contraindications to treatment, which include tumor, osteoporosis or spondylolisthesis.
- Informed me that Spinal Disc Decompression utilizing the SpineMED™ System is reported to have a 75% to 86% success rate. I further understand that I may get no benefit whatsoever from Spinal Disc Decompression.
- Informed me that it may take 15 to 20 sessions or more to see some relief from my discomfort.
- Informed me that taking anti-inflammatory medications can produce gastro-intestinal problems including nausea, abdominal pain and ulcers.
- Informed me that a trained technician will prepare me for the treatment, and monitor me during the treatment sessions. The Physician/ Practitioner will initiate the SpineMED™ System for each treatment session and be in contact with the technician during the treatment sessions.
- Informed me that any physical activity immediately following each treatment and for two to three weeks following completion of the entire treatment program should be kept to a minimum, as this is a vulnerable time for healing and exertion may cause re-injury.
- Informed me that a post-treatment evaluation by the SpineMED™ Clinician is a valuable way to assess any clinical benefit accrued from Spinal Disc Decompression.

I am aware with the fees associated with Spinal Disc Decompression.

I understand that my health information may be shared in an interdisciplinary manner with other health care agencies or providers and consent to the release of such information for 3rd party purposes.

Signature Patient

Witness Signature

Patient Name (Printed)

Witness Name (Printed)

Date

Date