JSR HEALTH PLLC

Rheumatology Clinic

LIVE YOUR BEST LIFE

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Rheumatology Office
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Thank you for choosing JSR Health PLLC for your medical care. We are dedicated to providing you with the utmost quality of treatment. Please complete the new patient consent forms to ensure your appointment confirmation. Kindly read and fill out the forms carefully.

Important Instructions for Filling Out the Consent Forms

- Please read the information carefully to develop your understanding before you begin filling out the forms.
- This form contains mandatory* fields that must be completed in order to submit the form successfully. These include Full Name, Date of Birth, Signature, Signature Date, Emergency Contact Details (Name, Relationship, Phone Number), etc. You cannot bypass these fields. Some information will be auto-populated; you do not need to enter any details in these fields.
- If you do not see the option to manually enter the signature date, leave that field blank; the signature date will be automatically captured upon submission.
- Enter “Y” for “Yes” and “N” for “No.”
- If there are no options to select “Yes” or “No” in the given checkboxes, please type “Y” in the check box corresponding to your choice.
- Under 'Relation with Patient': Type 'Self' if you are the patient. If you are signing the forms on behalf of the patient, please indicate your relationship with the patient - PoA, such as **Son, Power of Attorney**, etc.
- There are three options available for affixing your signature to the forms:

1. Draw your signature.
2. Type your signature, selecting from the available font options.
3. Upload a picture of your signature. (Preferred)

If you have any questions or require further assistance, please call us at **832-295-9186** from 08:00 AM to 05:00 PM (CST), Monday through Friday, excluding national holidays.

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CONSENT TO MEDICAL/SURGICAL OFFICE PROCEDURES

I (or my authorized representative, i.e., parent/guardian) ______________________ consent to the medical/surgical procedures outlined below to be performed by Dr. Jaya Sonkar, MD and her staff, associates, or assistants to whom the physician(s) performing the procedure may assign designated responsibilities. In the event one or more of the physicians is unable to perform or complete the procedure, a qualified substitute physician will perform or complete the procedure.

☐ YES ☐ NO The proposed medical/surgical procedure is a Large or small joint/ bursa injection/ trigger finger injection for the diagnosis/treatment of Joint arthritis/bursitis/intramuscular injection/subcutaneous injection. The procedure has been explained to me in terms that I understand. The explanation included:

- The nature and extent of the procedure to be performed.
- The most frequently occurring risks of the procedure involved, and those risks that are unlikely to occur but which may involve serious consequences, include but are not necessarily limited to the following: Infection, bleeding, injection not working, injection causing pain, increase in blood sugar and BP due to medication side effect, skin rash, anaphylaxis
- General risks which may include pain, scarring, bleeding, and infection.
- The benefits of the procedure.
- The estimated period of incapacity or convalescence, if any.
- The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all.

I was given the opportunity to ask any questions I have regarding the procedure and I have had those questions answered to my satisfaction.

I understand that I may consult or could have consulted with another physician about this procedure.

I understand that I have the right to refuse any medical/surgical treatment recommended at any time prior to its performance.

I authorize my physician to perform such additional procedures which in his/her judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.

If any unforeseen condition arises during this procedure that requires transportation to a hospital, additional procedures,

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure.

I authorize the physician performing the procedure, or his/her staff, associate, or assistant to whom the physician may assign the responsibility, to use his or her discretion in disposing of or using any tissue or body parts that may be removed during the procedure set forth above, subject to the following conditions (if any):

____

I authorize that a physician in training may participate in my care; a representative or technician from a medical

device company may be present at the procedure; medical photography may be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in the photo or text.

I acknowledge that I have read (or had read to me) and fully understand the above information.

Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits, and alternatives have been explained to my satisfaction. I hereby authorize my physician to perform the above-discussed procedure. Patient Initials________/Date___________ (Full signature required below)

Local Anesthesia

I understand the administration of an anesthetic is recommended. The benefit of the local anesthesia is greater comfort throughout the procedure. It has been explained to me that all forms of anesthetics involve some risks. I understand that no guarantees or promises can be made concerning the results of my procedure or the sedation technique administered. Complications with local anesthesia can occur and include inadequate anesthetic effect, drug reaction, and the possibility of infection, bleeding, or injury to blood vessels at the injection site. More severe complications could include anaphylaxis which could lead to serious consequences, including even loss of life.

Alternatives to sedation include no sedation at all and have been explained to me.

I acknowledge that I have read (or had read to me) and understand the above information on topical anesthesia. Furthermore, I certify that all my questions and concerns regarding the administration of a local anesthetic, its attendant risks, benefits, and alternatives have been explained to my satisfaction. I hereby authorize my physician and/or individuals qualified to do so, to administer this analgesic. Patient Initials_______/Date_________

Acceptance: You have read, understand, are legally able, and agree to the provisions of JSR HEALTH PLLC's Consent to Medical/Surgical Office Procedures. If this form is signed by anyone other than the patient, it is warranted that the signatory has the legal authority to do so.

Type Full Name: ______________________________ Relation with Patient: ______________

____ ________________________

Signature of Patient or Responsible Party Signature Date & Time

I verify that I have explained the information contained in this document to the patient or person giving consent. It is my opinion that the person granting consent has fully understood all subjects discussed.

_____________________________________ ____________

Dr. Jaya Sonkar, MD, MPH (Rheumatology) Date