Informed Consent
For Patients

I, ____

Give permission for *Joshua P. Prager, M.D., M.S. and Associates of the California Pain Medicine Center* to provide pain medicine treatment to me for my medical condition.

I understand that the role of Dr. Prager in my care will be that of a treating physician and consultant for pain related diagnoses. I further understand that Dr. Prager will not assume the role of my primary treating physician.

Pain management treatment planning will be clarified at my early visits. I understand that this care may be time limited and that I may be referred back to my primary treating physician when my condition has stabilized.

I also understand that Dr. Prager will document the care provided and that these records are available to other professionals involved in my are. In this regard, Dr. Prager will not be able to provide legal reports unless special arrangements are made upon my request, including additional fees where applicable.

I have read and understand the above.

____

Signature

____

Print Name

____

Date