Gina S. Nelson, M.D., P.C.
210 Sunnyview Lane, Suite 104
Kalispell, MT 59901
(406) 755-6550

Dr. Gina Nelson has discussed the following with me, ____________________________.

1. Diagnosis
2. Purpose of the procedure
3. Risks of the procedure
4. Alternatives to the procedure
5. Risks involved in the alternatives
6. Probable Outcome

I hereby request Dr. Gina Nelson and/or associates or assistants to perform the following procedure(s)/treatment(s): ______________________________

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I further permit my physician to produce appropriate photograph(s) of the above procedure(s), treatment(s) and permit such photograph(s), in which I am not identified, to be used for medical education purposes.

I fully understand that there is no guarantee that this procedure/treatment will improve my condition.

Dr. Gina Nelson has explained the above to me and I understand and I have no further questions.

I accept the above treatment   Patient Signature ______________________________
Date   Time

I refuse the above treatment and I agree to hold the hospital and Dr. Gina Nelson harmless for this procedure/treatment not being performed.

Patient Signature ______________________________
Date   Time

Or if the patient is unable to sign:

Relative/ Witness ____________________Relationship to Patient ____________________
Date   Time

Physician's Signature ____
Date   Time