NAU UROLOGY SPECIALISTS

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Patient Procedure/Treatment Consent Form
PTNS
(Percutaneous Tibial Nerve Stimulation)

Patient Name:_____ DOB: _____

I hereby authorize and direct _____ and assistants, as necessary to perform quality care, to perform the following procedure/treatment on me:

- ✔ PTNS (Percutaneous Tibial Nerve Stimulation)

The nature and purpose of the procedure/treatment, alternative methods of treatment, and potential risks and complications have been fully explained to me, including but not limited to:

- Site pain or bleeding
- Temporary worsen urgency
- Need for additional treatment

I acknowledge that no guarantees have been made to me as to the outcome of procedure(s) and/or treatment(s). I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: _____

Date: _____

Witness Signature: _____

Date: _____