

Consent for Prolotherapy

I request that Dr. Andrew Kochan treat me with proliferant therapy (prolotherapy).

Prolotherapy is a treatment for pain thought to be due to ligament or tendon damage. I understand that prolotherapy consists of a series of injections administered at two or three week intervals. The treatment is designed to induce ligament and tendon healing.

I understand that although this treatment has been in use since the 1950's it is not yet accepted as a "traditional" treatment by many physicians and is considered experimental by many insurance companies. There have been several clinical trials of this treatment published in the medical literature which have shown that it is safe and effective and produces significant improvements in a large majority of patients. I understand that I cannot expect a cure or have complete disappearance of pain but a gradual improvement over a period of months is likely but cannot be guaranteed.

I have looked into or tried the alternatives of putting up with the pain or taking medication, chiropractic adjustments, physical therapy, and surgery.

I understand that there are risks associated with any invasive procedure. In the 1960's there were several serious injuries including death and paralysis associated with prolotherapy but these were due to poor needle placement using a different solution and injection technique than used by Dr. Kochan. More common side effects include local soreness and/or swelling, bleeding, allergic reaction, pneumothorax (collapsed lung), nerve damage, damage to bone or ligament or tendon rupture.

My pain is long standing and severe and has not responded significantly to any other treatment. I have read this form and thought it over and discussed the treatment with you. By signing this form I do not relieve you from exercising due care on my behalf, but I do acknowledge and accept the risks involved.

Because this treatment is considered experimental by some insurance companies (in particular, Medicare and Blue Cross) proliferant therapy may be denied coverage in which case I will be financially responsible for the charges incurred.

This consent applies to any prolotherapy injections administered in the future.

Signed: _____

Date: _____