Foothills Neurology, P.C.

4530 E. Muirwood Drive #111 • Phoenix, AZ 85048 • 480.961.2365 • Stuart Hetrick, D.O.

Percutaneous Electrical Nerve Stimulation

Patient Name: ______________________________ **Date:** __________

Diagnosis: ______________________________ **TX #:** __________

Consent: *I have been fully informed about Percutaneous Electrical Nerve Stimulation (PENS) and the reasons for its use in my case. I am aware that the possible complications of this procedure include: localized discomfort, swelling, infection, bruising and risk of pneumothorax when working around the lungs.*

Financial Responsibility: *This is to inform you that the procedure (PENS) that you are requesting today may not be covered by your insurance. If it is not covered you will be responsible for $60. It is your responsibility to pay any applicable copay, coinsurance and/or deductible amounts. With your signature below, you are acknowledging that you understand and will comply with the above statement.*

Patient Signature: ______________________________ **Date:** __________

PENS Needle Sites:

Cephalic	Cervical	Thoracic	Lumbar	Thorax	Upper Extrem.	Lower Extrem.
____	____	____	____	____	____	____
____	____	____	____	____	____	____
____	____	____	____	____	____	____
____	____	____	____	____	____	____
____	____	____	____	____	____	____
____	____	____	____	____	____	____

Duration: ______________ **Settings:** *# of Channels* ______ *Location* ________

Vital Signs

Time:	am/pm	Needles inserted	
Time:	**am/pm**	**Needles removed**	

Notes: ***Pain level prior to TX:*** */10* Location: ______ ***Pain level following TX:*** */10* Location:

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Physician Signature: ______________________________ **Date:** __________

- ❑ Dictated Timothy Visser, ND
- ❑ **NOT** dictated

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