

Consent Form

I hereby authorize Dr. _____, and such assistants as may be designated, to perform:

Treatment

and any other related procedures or forms of treatment that they deem necessary for the welfare of:

(Name of Patient)

I understand that each person reacts differently to treatments / procedures, therefore, the expected results of said treatment cannot be guaranteed. The physicians and associates has discussed to my satisfaction the following:

- The nature and the character of the proposed treatment / procedure.
- The anticipated results of the proposed treatment / procedure.
- The recognized alternative forms of treatment / procedure.
- The recognized serious possible risks and complications of the treatment / procedure and of the recognized alternative forms of the treatment/ procedure, including non-treatment.
- The anticipated date and time of the proposed treatment / procedure

Additional
Comments: _____

My physician has offered to answer all inquiries concerning the proposed treatment / procedure. I understand that I am free to decline consent to the proposed treatment / procedure at any time.

Health Care Provider Obtaining Consent Date Signed

Signature of Person Giving Consent Date Signed