



CONSENT TO TREAT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, and any and all medication which in the judgment of my provider may be considered necessary or advisable for my diagnosis.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient's Full Name

Date of Birth

Patient's signature

Date

Parent, Guardian, or legal Representative Signature

Witness of Signature

