



Adult Authorization / Consent for Medical Treatment

I, _____, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical, and medical treatment, by authorized members of the practice staff or their designees, as may in their professional judgement deem necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my condition. I have read this form and certify that I understand its contents.

I hereby give my consent to Bowen Primary & Urgent Care (BPUC), until written notice has been given to Bowen Primary & Urgent care (BPUC) revoking this agreement, to arrange for routine or emergency medical care and treatment necessary to preserve my health.

I hereby give my consent to Bowen Primary & Urgent Care (BPUC) to draw any labs and process them through the laboratory of their choice.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Signature of Patient / Legal Guardian: _____ Date: _____

Printed Name of Legal Guardian (if applicable): _____

Legal Guardian Address (if applicable): _____

Legal Guardian Phone (if applicable): _____

Signature of Witness: _____ Date: _____

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|-------------------------------------|
| VERBAL CONSENT RECEIVED FROM: _____ |
| VERBAL CONSENT RECEIVED BY: _____ |
| DATE OF VERBAL CONSENT: _____ |

BPUC
PO Box 2268
Hickory, NC 28603
(828) 855-1192 (O)
(828) 358-0832 (F)

For additional copies of this form, please visit www.bowenmd.com/Signing-up