Bair Bones Osteopathic
Family Medicine Inc

Patient Name/DOB: _____
_____

GENERAL CONSENT TO TREATMENT

I consent to evaluation and treatment of the condition for which I, my child or dependent, have come to Bair Bones Osteopathic Family Medicine Inc, and authorize their physicians and other affiliated health care providers, to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by Bair Bones Osteopathic Family Medicine Inc. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Bair Bones Osteopathic Family Medicine Inc.

I have had an opportunity to discuss the information included in this form, and any questions I have had have been answered to my complete satisfaction.

Patient Name:

Signature of Responsible Party: Date:

Printed name and relationship of Responsible Party if not “Self” (e.g. mother, guardian, etc.):
