Affinity
BOTANICAL MEDICINE

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PATIENT CONSENT TO TREAT FORM

Consent for Medical Treatment:

Please read this form carefully. It outlines the terms of your consent for medical treatment at Affinity Botanical Medicine. Your understanding and agreement to these terms are essential for us to provide you with appropriate care. By signing this form, I, the undersigned patient (or legal guardian of the patient), hereby consent to and authorize the medical physicians and staff of Affinity Botanical Medicine to provide medical care, diagnosis, and treatment, including examinations, procedures, and any necessary medical services, as deemed appropriate and directed by the attending medical physician. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the outcome of any treatment.

I further understand and agree to the following:

1. Agreement to Treatment Plan: I agree to follow the treatment plan and directives as prescribed by the medical physician at Affinity Botanical Medicine. I understand that adhering to this plan is crucial for my health and the effectiveness of the treatment.
2. Accurate Medical History Disclosure: I affirm that I have provided, to the best of my knowledge and ability, accurate, truthful, and complete information regarding my medical history, current symptoms, allergies, medications, and any other health-related information pertinent to my care. I understand that withholding or misrepresenting medical information can have serious implications for my health and treatment.
3. Required Documentation: I confirm that I have provided all required documentation requested by Affinity Botanical Medicine necessary for my treatment and medical record.
4. No Additional or Additive Treatment: I agree not to seek additional or additive treatment, prescriptions, or medical advice from other physicians or healthcare providers for the conditions being treated by Affinity Botanical Medicine without prior discussion and approval from my attending physician at this clinic. I understand that receiving concurrent or overlapping treatments without coordination can pose risks to my health and interfere with my care plan.
5. Awareness of Prescription Monitoring (KASPER - Kentucky All Schedule Prescription Electronic Reporting): I am aware that, as required by the state of Kentucky, Affinity Botanical Medicine utilizes and reviews the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system. This system monitors prescriptions for controlled substances to prevent drug abuse and diversion. I understand that information regarding my controlled substance prescriptions will be accessed and shared through this database as mandated by state law.

Patient Acknowledgement and Agreement

I, the undersigned patient (or legal guardian of the patient), acknowledge that I have read, understood, and agree to the terms of this Consent to Treat form for services at Affinity Botanical Medicine.

Patient or Representative Signature	Print Name	Date