



## INFORMED CONSENT FOR INVASIVE TREATMENT PROCEDURE

<b>Xpress Location</b>			
<b>Patient Name</b>		<b>Patient DOB</b>	
<b>Medical Provider</b>			

I (or my authorized representative, i.e., parent/legal guardian), \_\_\_\_\_, consent to the medical/surgical procedures outlined below to be performed by Xpress Urgent Care’s medical provider and his/her staff, associates, or assistants to whom the provider performing the procedure may assign designated responsibilities.

- Pelvic Exam
- Other: \_\_\_\_\_

I also understand that I may feel some pain during and after the procedure. Other risks may include bruising, or infection. There may be other risks or things for me to consider before I agree to this procedure. I understand that this procedure is voluntary and that I have the right to refuse any medical treatment recommended at any time prior to its performance.

By signing this form, I acknowledge that I have discussed and understand the risks, benefits and alternatives of the procedure as indicated with my health care provider and all my questions have been answered.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship, if not patient:** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_