I consent to allow Stephanie F. Cave, MD and her designated associates to treat me medically using whatever treatment they determine medically necessary or advantageous for me. I understand that some of the treatments and diagnostics tests offered in this office are not used by the majority of doctors in the community.

I understand that they will discuss the usefulness and costs of the treatment, and that I will have a choice as to whether or not to participate in the treatment.

I will also have the opportunity to discuss any risks involved in testing of treatment with Stephanie F. Cave, MD and her designated associates.

I agree to be personally responsible for any charges incurred in the office of Stephanie F. Cave, MD and her designated associates for diagnostic testing and treatment. This includes any charges that may or may not be covered in full by any insurance company for any reasons.

PATIENT'S PRINTED NAME _____

PATIENT'S GUARDIANS _____ DATE _____

WITNESS _____ DATE _____

WITNESS _____ DATE _____

STEPHANIE F CAVE, MD _____ DATE _____

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