CONSENT FOR MEDICAL TREATMENT

Patient Name: _____ Date of Birth: _____

I hereby authorize [PractitionerName] and/or such assistants as may be requested by said physician to perform the above noted medical treatment as explained to me. I hereby acknowledge and agree that if my insurance does not cover the treatment authorized above, I will be personally responsible for paying the financial charges for those services.

I understand that this medical treatment is not without risks. The benefits and risks have been explained to me.

Potential risks associated with the medical treatment include but are not limited to the risk of infection at the site of incision, bleeding that may requiring a secondary procedure, scar tissue formation and discomfort or pain at site.

I accept the treatment recommendation of my physician. I acknowledge that no warranty or guarantee has been made as to the results of this treatment. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my physician. I further certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of this treatment, of the possible alternative treatment choices, and the possible risks, complications, and anticipated benefits involved in the proposed treatment, including non-treatment.

The procedure as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent is thus given as noted by signature.

_____ _____

Patient or Responsbile Party Signature Date