arbor place
family medicine

Patient Name: ______________________________

DOB: ______________

Consent to Medical Treatment

In consideration of medical services to be rendered to me (herein referred to as Patient) at Arbor Place Family Medicine P.C. (herein referred to as "Medical Practice"), Patient does hereby consent as follows:

1. Consent and Treatment Authorization

Patient (or the undersigned asking on behalf of Patient), who is requiring medical treatment, does hereby consent to the rendering of such care and treatment, which may include diagnostic procedures and such medical treatment and care as the Attending Physician or other physicians of the Medical Practice staff consider to be necessary and appropriate. In the event that the Medical Practice should decide that blood specimens should be provided by the Patient for testing purposes in the interest of the safety of those with whom Patient may come in contact, Patient does hereby consent to such blood withdrawal and for the testing thereof, as well as to the release of test information where this is deemed medically appropriate or required by law.

2. Disclaimer of Guarantee

Patient hereby acknowledges that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury and of adverse results. Patient hereby acknowledges that no guarantees have been made to Patient or those acting for Patient as the results of procedures which Patient may undergo while a patient of Medical Practice.

3. Acknowledgments of Patient

Patient understands that:

- It is customary, absent emergency or extraordinary circumstances, that no substantial or invasive medical procedures be performed upon a patient unless and until the patient has had the opportunity to discuss these procedures with the physician or other health professional so that the patient may be informed of the contemplated procedures.
- Each patient has the right to consent, or refuse to consent to any specific procedure or therapeutic course of treatment.

4. Patient Understanding of Consent

This Consent Form has been adequately and fully explained to Patient, and Patient, by his or her signature, indicates satisfaction as to an adequate understanding of this Consent and of its significance and that Patient is voluntarily executing the same.

5. Validity of Consent

This consent is valid during the entire term of my association with Arbor Place Family Medicine P.C. and may be relied upon by Arbor Place Family Medicine P.C. unless, and until, revoked by Patient, in writing.

PERSON GIVING CONSENT (SIGNATURE): ____

PERSON GIVING CONSENT (PRINT NAME): ____

RELATIONSHIP TO PATIENT IF NOT THE PATIENT: ______________ DATE: ________________

PATIENT UNABLE TO SIGN BECAUSE: ____

WITNESS: ______________________________________ DATE: __________________________