Consent to Treat Form for Adults

Patient Information
Name:
Date of Birth:
Address:
Phone Number:
Emergency Contact:
Relationship:
Phone Number:
Healthcare Provider Information
Name of Physician / Healthcare Provider:
Facility Name:
Address:
Phone #:

Consent for Treatment

I, , hereby give my consent to the physicians, nurses, and other healthcare staff at to perform medical treatments and procedures that are deemed necessary for my diagnosis, treatment, or care. I understand that this may include, but is not limited to, diagnostic tests, blood tests, radiological exams, surgical procedures, anesthesia, and other medical or surgical treatments.

Informed Consent

I acknowledge that the nature of my condition has been explained to me, along with the purposes, potential risks, benefits, and alternatives to the proposed treatment(s), including no treatment. I have been allowed to ask questions and have received satisfactory answers to all of my questions.

I understand that there are no guarantees about the outcomes of the treatment or procedure and that unexpected or unanticipated risks or complications may arise. I also recognize the right to withdraw my consent or refuse treatment at any time.

Privacy and Confidentiality

I understand that my health information will be treated as confidential and shared only as required or permitted by law, including disclosures to health insurance providers for billing purposes.

Release of Liability

By signing this form, I release the healthcare provider and facility, along with its staff, from any liability associated with the treatments or procedures, provided that these services are performed with due care and by the standards of medical practice.

Acknowledgment

I have read (or had read to me) this Consent to Treat Form. I fully understand its contents and implications. I acknowledge signing this consent voluntarily and with full knowledge of its significance.

Patient Signature: **Date:**

Witness Signature (if applicable): **Date:**

Physician/Healthcare Provider Signature: **Date:**