

**Practice Letterhead**

**Consent to Treat** *(Form Example. Please have your legal counsel review before using)*

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Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Time: \_\_\_\_\_ (A.M./P.M.)

I hereby give my consent and authorize \_\_\_\_\_ to treat the following conditions:

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by performing the following procedure(s):

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The care provider has explained my condition to me, the above treatment procedure and alternative methods of treating my condition.

The care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.

I authorize the care provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which was not known previously.

I consent to the administration of local, regional or general anesthesia and/or sedation as most appropriate for the above procedure. For those procedures that have a potential for significant blood loss, I consent to the transfusion of blood or blood components as necessary.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All of my questions have been adequately answered.

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Signature of Patient

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Date

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Signature of Parent/Legal Guardian (for minor)

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Relationship to the Patient

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Signature of Care Provider

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Date