Account # ______________

Consent for Treatment

Treatment and Consent. I am being treated at Doctors Care and I consent to all medical/dental and surgical care, examinations, vaccinations, radiographs and other treatment/tests determined by my Provider that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Provider's recommendations as they may relate to my health that the Provider and this Office will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if an employee or any individual associated with Doctors Care is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

Patient Name _______________________________________ Patient Date of Birth ________________

Patient/Parent/Guardian Signature _____________________________ Today's Date ______________

If not signed by patient, please indicate relationship:

☐ Parent or guardian of minor patient ☐ Guardian or Conservatory of an incompetent patient