Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center• Harvest Family Health Center •Wilson Community Health Center

INFORMED CONSENT

_____ _____

Patient's Name (Printed) *MR#*

_____

Treatment/Procedure

I hereby acknowledge that I have been fully informed as to 1.) the nature of the procedure, 2.) the risks and complications involved with the procedure, including fatal complications and dissatisfaction with the results 3.) the perceived benefits associated with the above named treatment/procedure; and, 4.) the alternative options are available to me. I understand that it is my right to have all questions answered to my satisfaction and to refuse treatment/procedure at any time.

_____ _____

Patient/Guardian's Signature *Date*

I hereby acknowledge that the patient/guardian has been given full disclosure in relation to the above named treatment/procedure. The patient/guardian appears to understand the risks, the probable consequences, and the alternatives to this treatment modality.

_____ _____

CFHC, Inc. Health Care Provider's Signature *Date*

Both signatures witnessed this _____day of _____, _____.
Month *Year*

_____

Witness' Signature