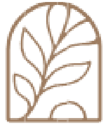

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TREATMENT CONSENT FORM

Patient Information

Full Name: ______________________________

Date of Birth: ___________________________

Age: __________

Address: ________________________________

Phone Number: ___________________________

Parent / Legal Guardian Information

Full Name: ______________________________

Relationship to Patient: _________________

Phone Number: ___________________________

Consent for Treatment

I understand that the patient named above is receiving care and/or treatment from

Provider / Clinic Name: ______________________________

The nature and purpose of the treatment have been explained to me in a way I understand. I have had the opportunity to ask questions, and all my questions have been answered.

I understand that:

- No guarantees have been made about the results of treatment
- Treatment may involve risks or side effects, which have been explained

- I may withdraw consent at any time by informing the provider

I give my permission for the healthcare provider to perform medically necessary examinations, procedures, and treatments within their scope of practice.

Emergency Treatment (optional)

In the event of an emergency, I authorize the provider to give any necessary treatment to protect the patient’s health and safety.

☐ Yes ☐ No

Acknowledgment and Signature

I confirm that the information provided is accurate and that I voluntarily give consent for treatment.

Parent / Guardian Signature: ___________________________

Printed Name: ____________________________

Date: ____________________

Patient Signature (if applicable): ______________________

Date: ____________________

Provider / Witness Signature: __________________________

Date: ___________________