

Consent to Treat

Patient Name (printed): _____ DOB: _____

- I voluntarily consent to receive medical care and treatment by the healthcare providers and staff at Central Florida Rheumatology Consultants.
- I understand that this may include routine diagnostic procedures, physical examinations, and medical treatments, including emergency services, as deemed necessary by the provider.
- I understand that the practice of medicine is not an exact science and that no guarantees have been made to me about the outcome of my treatment or examination.
- I understand that I have the right to refuse any service or treatment to the extent permitted by law and that it is my responsibility to ask questions if I do not understand any information or instructions given to me.

By signing below I agree to the above terms.

Patient Signature: _____ Date: _____