

CONSENT TO TREATMENT

The policies and practices of Michael Juboori, M.D., are described in the document, "Office Policies and Practices 2019." You have been given a copy of "Office Policies and Practices 2019" for review. The purpose of this form is:

1. For you to give your consent, in writing, to receive services from Michael Juboori, M.D.; or
2. If you are consenting on behalf of your child, for you to give your consent, in writing, for your child to receive services from Michael Juboori, M.D.

I/We understand the following:

- That our decision to seek services from Michael Juboori, M.D. is voluntary. I have read the document entitled, "Office Policies and Practices 2019," and I understand the policies and procedures detailed in it. I agree to adhere to the policies and procedures detailed in this document and I consent to receive services from Michael Juboori, M.D.
- That I/we have been fully informed about the nature, risks and benefits of treatment, and the availability of treatment options.
- That I/we have had the opportunity to have all questions answered to my/our satisfaction.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent for this treatment at any time.
- That Dr. Juboori may receive professional consultation with regard to patient care. I consent to have Dr. Juboori disclose my private information to consultants and colleagues for the purpose of professional consultation.

Please sign below to indicate that you agree with all statements above and that you consent to receive services from Juboori, M.D.

Signature _____ Date _____