

MEDICAL TREATMENT CONSENT FORM

Patient Name: _____ Date: _____

I, the undersigned, do hereby authorize the performance of medical treatment, procedures, and diagnostic tests that in the judgment of my attending physician or their designees are deemed necessary for my care and well-being. I understand the nature and purpose of the proposed treatment, as well as alternative options and potential risks.

PATIENT RIGHTS AND RESPONSIBILITIES

- I understand I have the right to informed consent and to refuse treatment.
- I agree to follow the treatment plan and hospital rules.

TREATMENT AUTHORIZATION

I consent to all necessary treatment.

I limit my consent to: _____

PRIVACY NOTICE ACKNOWLEDGMENT (HIPAA)

I acknowledge receipt of the Notice of Privacy Practices.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand I am financially responsible for all charges not covered by insurance.

Patient Signature: _____ Date: _____

Guardian/Legal Representative Signature (if minor):
_____ Date: _____

Witness Signature: _____ Date: _____