GRACE GYNECOLOGY & WELLNESS, APMC

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment after knowing the risks and hazards involved. This consent form is simply an effort to obtain your consent to perform the necessary evaluation to help identify the appropriate treatment or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. This consent is in effect until it is revoked in writing. You have the right, at any time, to discontinue services from this health care provider.

You have the right to discuss the treatment plan with your provider about the purposes, risk, and benefits of any test, medication, or procedure ordered for you. We encourage you to ask questions.

By signing this form, I request a physician provider or assistant to perform reasonable and necessary medical for the examination, testing, and treatment for the condition that has brought me here to seek care at this practice. I acknowledge that I have read this form and fully understand and accept its terms.

_____ _____

Signature of patient or representative **date**

_____ _____

Printed name of patient or representative **relationship to patient**

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