General Consent to Treatment

Patient Name:
Date of Birth:

General consent to treatment: By signing below, I, (or my authorized representative on my behalf) authorize Pediatric Associates and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my/my child's health, and to assess, diagnose and treat my/my child's illness or injuries. I understand that it is the responsibility of my healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, the common risks, anticipated burdens/benefits associated with these options, and alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my health care provider. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____
Signature of Patient or Responsible Party Date: _____

_____
Print Name

_____
Relationship to Patient