

# Consent to Treatment



Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Chart #: \_\_\_\_\_ Today's Date: \_\_\_\_\_

I voluntarily consent to receive medical and health care services that may include examinations, diagnostic procedures, and treatments.

I understand there are risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia, numbness and/or lack of sensation, and the formation of thick or otherwise objectionable scars.

I give my permission to have any tissue(s) removed during the office visit to be sent for histology examination by a pathologist. I understand that the histological examination will be a separate charge and that I could receive a bill from a different organization for said examination.

I understand the results will be available within 10 business days. If I have not received the results within 10 business days I will call the office.

Phone Number to Call with Results: \_\_\_\_\_

May we leave a detailed message at the above phone number?  Yes  No

Best Time to Call: \_\_\_\_\_

Person(s) it is okay to discuss results with: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Patient's Representative/Legal Guardian signifying informed consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

*\* This consent is valid for one year from above date*