HIPPA Consent for Treatment

Name: _____
hereby voluntarily consent to the rendering of care.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments.

I have read this form and certify that I understand its contents. I hereby give my consent to arrange necessary treatment.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment.

Printed Name _____
Signature_____
Date_____