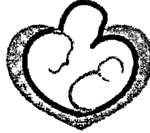

GILA VALLEY CLINIC, PC
1680 S. 20th Avenue
Safford, Arizona 85546
928-428-1377 Fax 928-428-6903

PATIENT CONSENT TO TREAT

NAME:________________________________ DOB:______________

I am seeking medical care and treatment that are believed to be necessary by the medical staff and other healthcare professionals of the Gila Valley Clinic.

I understand that I have the right to refuse consent to any proposed care, treatment, testing, surgery or procedure.

I understand that I have the right to ask questions and discuss my concerns with my healthcare provider.

I am aware that the practice of medicine is not an exact science.

I understand that diagnosis and treatment involve risks.

I acknowledge that no promises can be made to me as to the outcome of my care, examination or treatment, or that everything will go as planned.

I hereby authorize and give consent to have a photos taken by the medical staff or healthcare professionals for the sole purpose of documentation for my medical records, which are confidential. I understand that my participation is completely voluntary and I can refuse to have a photo picture taken at any time.

I HAVE READ OR HAD READ TO ME AND UNDERSTAND THE CONTENT OF THIS CONSENT FORM IN ITS ENTIRETY. ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I GIVE CONSENT FOR TREATMENT FOR MY MEDICAL SERVICES.

X____

Signature of patient/parent of minor/legal representative **(Relationship if not patient)** **Date**