General Health Treatment Consent Form

Date: _____

Patient Information

Full Name:

_____

Date of Birth:

_____

Address:

_____

Phone Number:

_____

Email:

_____

Consent for Treatment

I hereby authorize the healthcare provider and their designated staff to perform general health treatments and procedures as necessary for diagnosis, treatment, and prevention of medical conditions. I understand that the nature and purpose of the proposed treatments, their risks and benefits, and any possible alternatives have been explained to me and all my questions have been answered to my satisfaction.

I acknowledge that no guarantees or promises have been made to me regarding the outcome of any procedure or treatment. I have the right to refuse or withdraw consent at any time.

Patient Acknowledgment

By signing below, I confirm that I have read and understood this consent form, and that I voluntarily agree to the proposed medical care.

Patient/Guardian Signature:

_____

Date:

_____

Healthcare Provider Name:

_____

Date:

_____