

Consent to Treat and Waiver of Liability

I hereby voluntarily consent to receive treatment and authorize the healthcare provider or authorized personnel to administer such treatments, procedures, or therapies as are deemed necessary in their judgment.

I acknowledge that no guarantees have been made to me regarding the outcome of the treatment or services provided.

I understand and accept that receiving treatment may involve certain risks, including but not limited to potential side effects, complications, or unforeseen outcomes, and I voluntarily assume all such risks.

By signing below, I waive, release, and discharge the healthcare provider and its staff from any and all claims, liabilities, or damages arising from participation in treatment, except for those arising from gross negligence or willful misconduct.

Signature of Patient/Guardian

Printed Name

Date