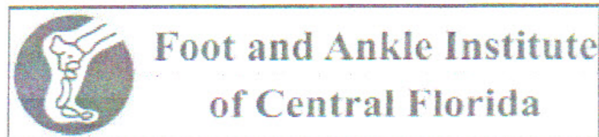


## PATIENT CONSENT TO TREATMENT

**PURPOSE:** As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy. This disclosure is to inform you so you may give or withhold your consent to the proposed treatment.

**CONSENT TO TREATMENT:** I voluntarily request Dr. Poncheri as my physician and such assistants, nurses, and other health care providers as she may deem necessary or advisable to treat my condition. I understand that it is my responsibility to actively participate in my care in order to maximize improvement in my condition.

I understand I ay undergo diagnostic tests and examinations during my treatment at FAICF. If I am unable or unwilling to undergo such testing, my treatment plan may be revised, and my outcome affected. I also may be required to make frequent follow up visits to review results and clinical progress. I understand I must be present at the time of recommended follow up office visits.

I will keep my physician and authorized associate(s) apprised of any change in my medical condition. Certain diagnostic tests, treatments and drug therapies may be dangerous under certain medical conditions. One example is pregnancy. Female patients who become pregnant during the course of treatment at FAICF must notify their physician.

I understand the treatment of my condition will be directed initially toward conservative management, unless an emergent or urgent surgical procedure is immediately required. Failure of conservative care may lead to recommended surgery.

**This consent was reviewed and signed by**:______________________________
Printed Name- Patient or Representative

______________________________ ____________________
Patient/Representative Signature Date

**Witness:** ________________________________________
Name

______________________________ ____________________
Signature Date