**CONSENT FOR TREATMENT**

I request those physicians and other healthcare professionals who care for me at the practice to perform/order appropriate laboratory/diagnostic procedures and provide therapeutic treatments, which in the judgment of my physician or other healthcare professionals are medically necessary in the course of my medical treatment or preventative care. I also understand that it is the policy of this practice to perform urine testing on patients when appropriate, including urine pregnancy testing on every patient of childbearing age unless they have had a complete hysterectomy.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made or will be made to me as to the results of any professional services that may be received by me as a patient of the practice; i.e. treatments, examinations, procedures, etc. I authorize my provider to retain, preserve and use for scientific or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body during a visit. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for education purposes.

I consent to telephone, synchronous audio-visual or digital communication with my physicians and other healthcare professionals at practice as an alternative to a face-to-face visit to provide care or treatment.

I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS.

Patient Signature: _____ Date: _____