Patient Informed Consent Form

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### Part 1: Personal Details

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Part 2: Medical Service Information

**Service to be Rendered: \_\_\_\_\_\_\_\_\_\_\_\_\_
Provider's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Part 3: Acknowledgment of Information Receipt

I acknowledge that I have received and understood all information regarding the medical services to be provided. I have had the opportunity to ask questions and receive answers.

### Part 4: Consent

By signing below, I consent to the medical services described above and acknowledge that I am doing so voluntarily.

**Checkbox: ☐ I Agree to the Terms Stated Above**

### Part 5: Signature

**Patient's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Table: Follow-up Appointments (if applicable)

| **Date** | **Time** | **Provider** | **Notes** |
| --- | --- | --- | --- |
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