CONSENT TO TREATMENT FORM

Ensure patient understanding and agreement for ongoing medical care and treatment plans

BRIGHT CLINIC

PATIENT INFORMATION

|  |  |
| --- | --- |
| **Patient Name:**  | @Name here  |
| **Patient ID:**  | ID here  |
| **Date of Birth:**  | **Mar 14, 2030**  |
| **Address:**  | Address here  |
| **Phone:**  | Phone number here  |
|  |   |
| **Department:**  | Department here  |
| **Provider:**  | Provider here  |

CONSENT TO TREATMENT

I **[full name here]**, born on **[date of birth here]**, give my voluntary and informed consent to receive the treatment or procedure described as **[treatment or procedure name]**, which has been explained to me by **[healthcare provider’s name]**.

I understand the nature, purpose, expected beneﬁts, potential risks, and possible alternatives to this treatment, including the option to decline or delay care.

I acknowledge that I have had the opportunity to ask questions, that all my questions were answered in a way I understand, and that I feel comfortable proceeding. I understand that I may withdraw my consent at any time without affecting the quality of my future care. I also understand that this consent covers the planned treatment and any necessary adjustments made in my best interest during the course of care.

By signing below, I conﬁrm that I have read this form (or had it read to me), that I understand its contents, and that I freely give my permission to proceed with treatment.

SIGNATURES

|  |  |
| --- | --- |
| **Signature of Patient or Guardian:**  | Signature here  |
| **Date:**  | **Mar 14, 2030**  |
| **Signature of Provider or Witness:**  | Signature here  |
| **Date:**  | **Mar 14, 2030**  |

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