CONSENT FOR TREATMENT

1. I hereby do voluntarily consent to such care including routine procedures and other treatments by Edge Family Medicine professionals and their assistants, appointees, or consultants, as is necessary in their judgement.

2. I am aware the practice of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in Edge Family Medicine.

3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Furthermore, if I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.

4. I understand that Edge Family Medicine shall not be responsible or liable for the loss of, or damage to any personal property.

5. I authorize release to any party responsible for my care—including information from my records— in order for the group and all entities providing services to obtain payment. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

I have read the above statement and my questions have been adequately answered and I certify that I understand its contents.

Print Patient Name ______________________________________Date of Birth__________

Signature of Patient ______________________________________Date ________________

Signature of Parent or Guardian ____________________________Relationship__________