

CONSENT TO TREATMENT

Name of Patient: _____

Name of Primary Cardiologist: _____

Date: _____ Time: _____ AM/PM

1. I, (or _____, acting on behalf of) _____, hereby consent to medical treatment, which may include routine diagnostic procedures and other such medical treatment as the named physician(s) or other physician of Fort Wayne Cardiology considers to be necessary.
2. I understand that the practice of medicine is not an exact science and may involve risks.
3. I understand that:
 - a. It is customary, absent emergency or extraordinary circumstances, that no substantial procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professional to the patient's satisfaction.
 - b. Each patient has the right to consent, or to refuse to consent, to any proposed procedure or course of treatment.
 - c. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent.
4. I am satisfied that I understand the content of this form and its significance.

Patient: _____ Date: _____

Witness _____

If patient is unable to consent or is a minor, complete the following:
Patient (is a minor _____ years of age) (is unable to consent because):

Legal guardian or closest available relative: _____

Witness: _____