McDonagh Medical Center

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Nutrition · Allergies · Family Practice · Degenerative Diseases · Preventative Medicine · Metabolic Disorders · Prolotherapy

CONSENT TO MEDCIAL TREATMENT

Patient Name_____DOB_____Date_____

1. I hereby voluntarily consent to treatment and procedures by McDonagh Medical Center, his assistants or his designees as is necessary in the judgement of McDonagh Medical Center.
2. Permission is granted for prescriptions for my family to be packaged in containers without child-resistant safety caps.
3. It has been explained to me and I understand that Medicare or other health insurers do not generally cover the vitamin and mineral supplements at the clinic.
4. I agree that if I accept treatment, I shall be responsible for payment of all costs at the time of services.
5. Filing of insurance claims shall be on my own responsibility.
6. I have read and fully understand the information above.

Patient Signature_____Date_____

Patient Print Name_____

If patient is a minor or unable to consent, complete the following:

Patient (is a minor ___ years of age) or is unable to sign because _____

_____

Signature of legal guardian/power of attorney_____Date_____

Witness _____Date_____