

# AZUREWAVE MEDICAL SERVICES, LLC

## General Consent to Treat

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

I voluntarily consent to receive medical evaluation, diagnosis, and treatment from AzureWave Medical Services, LLC and its physicians, providers, and clinical staff.

I understand that medical care may include, but is not limited to:

- Medical history and physical examination
- Diagnostic testing
- Laboratory testing
- Preventive care
- Minor procedures
- Prescription of medications
- Other services considered medically appropriate

I understand that the practice of medicine is not an exact science and that no guarantees have been made regarding the results of my treatment.

I acknowledge that I have the opportunity to ask questions regarding my care and that my questions have been answered to my satisfaction.

By signing below, I authorize AzureWave Medical Services, LLC to provide medical care and treatment as deemed appropriate.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If signed by legal guardian or authorized representative:

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_