

MEDICAL TREATMENT CONSENT FORM

Patient Name:	
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Consent for treatment: Knowing that I (or the patient indicated on the top of this form) desire evaluation and/or treatment at Pioneer Physicians, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, administration of medication and to medical or surgical treatment by physicians and staff members of Pioneer Physicians and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guaranties have been made to me as to the results of my examination or treatment at Pioneer Physicians.

I acknowledge that treatment at Pioneer Physicians is intended to address specific episodic illnesses or injury and is not intended to substitute for comprehensive care in lieu of a primary care physician or other specialized physician. In order to provide the best chance for successful treatment I accept responsibility to follow the advice of my treating physician including compliance with medications, discharge instructions and reevaluation with follow up or referral physicians. I agree to return to Pioneer Physicians seek care in an Emergency Department of a hospital if my condition substantially changes.

I further agree to hold harmless the physicians and staff of Pioneer Physicians should I fail to comply with the above conditions. Patients at Pioneer Physicians will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above criteria, Pioneer Physicians reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of the physician on duty.

This consent shall remain in force until such time as it is specifically revoked

Signature (Patient, Parent, or Legal guardian).	Today's Date / /
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Representative signature required if the patient is a minor or unable to consent