Consent to Treat Agreement

I hereby voluntarily consent to evaluation, treatment, and care provided by [Provider Name/Facility] and its clinical staff. I understand that such treatment may include but is not limited to physical examinations, diagnostic procedures, medical and/or psychological treatment, and other healthcare services as considered necessary by the provider.

I acknowledge that I have been informed about the nature and purpose of the recommended procedures and treatments, including potential risks and benefits. I understand that I may withdraw my consent and discontinue participation in these treatments at any time.

I understand that my health information will be treated confidentially and in accordance with applicable laws and regulations. My questions regarding this consent have been answered to my satisfaction.

Patient Name

Date of Birth

Date

Patient or Legal Guardian Signature