myhomedoctor

My Home Doctor, LLC
Tel 888.696.4322 · Fax 877.409.3320

PATIENT FORMS

Medical consent form

PATIENT

Patient information

FIRST NAME *

LAST NAME *

DATE OF BIRTH *

mm/dd/yyyy

CONSENT

Consent to treatment

I, _____, do hereby agree and give my consent to the medical provider to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition. I understand my physician may utilize an APRN(s), a PA(s) and/or nurse(s) to assist with my plan of care.

PATIENT SIGNATURE *

SIGN HERE

DATE *

mm/dd/yyyy

CONFIDENTIAL: This form contains protected health information (PHI). Do not leave it unattended or share it with anyone other than My Home Doctor or your authorized representative.