Patient Treatment Consent Form

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Consent to Treatment

I, the undersigned, consent to the treatment procedures provided by the healthcare professionals at [Healthcare Facility Name]. I understand that the purpose of the treatment is to improve my health condition and that the expected benefits, risks, and alternatives have been explained to me.

Risks and Benefits

I acknowledge that the risks and benefits of the treatment have been discussed with me, including but not limited to:

- Potential risks: _____
- Expected benefits: _____
- Alternative options: _____

Voluntary Consent

I understand that I have the right to refuse treatment and that I have the right to ask questions regarding the treatment before signing this consent form.

By signing this form, I acknowledge that I have read and understood the information provided and that I consent to the proposed treatment.

Signature of Patient: _____

Signature of Guardian (if applicable): _____

Date: _____