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CONSENT FOR MEDICAL TREATMENT

Patient Name:

Date of Birth:

I hereby authorize [Azra Niaz MD] and/or such assistants as may be requested by said physician to perform the above noted medical treatment as explained to me. I hereby acknowledge and agree that if my insurance does not cover the treatment authorized above, I will be personally responsible for paying the financial charges for those services.

I understand that this medical treatment is not without risks. The benefits and risks have been explained to me in detail.

Potential risks associated with the medical treatment include side effects of medications that may have been prescribed to me, have been discussed by the provider.

I accept the treatment recommendation of Dr Niaz. I acknowledge that no warranty or guarantee has been made as to the results of this treatment. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my physician. I further certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of this treatment, of the possible alternative treatment choices, and the possible risks, complications, and anticipated benefits involved in the proposed treatment, including non-treatment.

The possible risks, complications, options, and expectations have been explained to me or my representative and consent is thus given as noted by signature.

Patient or Responsible Party Signature

Date