Pediatric Associates of Lewiston P.A.

General Consent to Treatment

Patient Name:
Date of Birth:

General consent to treatment: By signing below, I, (or my authorized representative on my behalf) authorize Pediatric Associates and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my/my child's health, and to assess, diagnose and treat my/my child's illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associates with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

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Signature of Patient or Responsible Party Date: