TREATMENT CONSENT FORM

I hereby consent to the following:

- Administration and performance of all treatment.
- Administration of any needed anesthetics.
- Performance of such procedures as may be deemed necessary or advisable.
- Use of prescribed medications
- Performance of diagnostic procedures or test.
- Performance of other medically accepted and needed laboratory tests and/or procedures based on the judgement of the attending physician or their designee.

I fully understand that this is given in advance of any specific diagnosis or treatment

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I, the undersigned acknowledge that HovaCare Clinic will use and disclose my information for the purpose of a treatment, payment, and other health care operation

A photocopy of this consent shall be considered as valid as the original

Medicare/Medicaid patients: I authorize the release of medical information about me to the social security administration or its intermediaries. I assign the benefits for service to HovaCare clinic.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name____

Patient date of birth____

Patient Guardian (if minor) /Financial Guarantor Name_____________________________________

Patient/Patient Guardian (if minor)/Financial Guarantor Signature____________________________

Date____