UBMD ORTHOPAEDICS & SPORTS MEDICINE

Patient Consent to Treatment

Please Read Carefully

I hereby authorize the healthcare providers at UBMD Orthopaedics & Sports Medicine to provide medical evaluation, treatment, and procedures deemed necessary for my care. I understand that:

1. **Nature of Treatment** – My treatment may include diagnostic tests, physical examinations, therapeutic procedures, medications, and other medical interventions appropriate for my condition.
2. **Risks and Benefits** – My provider will explain the potential risks, benefits, and alternatives associated with my treatment plan. I acknowledge that no guarantees have been made regarding outcomes.
3. **Right to Refuse Treatment** – I have the right to ask questions and refuse treatment to the extent permitted by law. I understand that refusing recommended care may impact my health.
4. **Financial Responsibility** – I acknowledge that I am financially responsible for any services provided to me, including services and fees not covered by insurance.
5. **Privacy and Confidentiality** – My medical information will be handled in accordance with HIPAA regulations to protect my privacy, except as required by law.
6. **Continuity of Care** – My healthcare providers may collaborate with other medical professionals to ensure comprehensive care.

By signing below, I confirm that I have read and understand this consent form, have had the opportunity to ask questions, and voluntarily consent to treatment.

Print Patient Name:_____ Patient DOB: _____

Patient Signature_____ Date: _____

Name of Parent or Legal Guardian (if applicable)_____

Signature of Parent or Legal Guardian (if applicable): _____ Date: _____

DOCUMENT NO: CON002.01-AK
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