**OMEGA HEIGHTS FAMILY MEDICINE CLINIC**

**PATIENT CONSENT TO TREAT**

I here by give my consent to Omega Heights Family medicine clinic and authorize him/ her to provide my medical treatment. I understand Omega Heights Family medicine clinic will explain my conditions, foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Omega Heights family medicine to perform additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this patient consent to Treat form and I have had the opportunity to discuss my condition with my provider.

Patient Name -----------------------------------------------------

Patient signature ------------------------------------------------- Date -----------------------

Parent/ legal guardian if minor ----------------------------------------