Renée C. Smith M.D., FACOG
Wise Obstetrics & Gynecology, P.A.

PATIENT CONSENT TO TREAT

I hereby give my consent to Wise Obstetrics & Gynecology and authorize him or her to provide my medical treatment. I understand that Wise Obstetrics & Gynecology will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Wise Obstetrics & Gynecology to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I understand that payment is due at the time services are provided. Pre-payment is required for non-emergent surgery and delivery care.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient Name _____

Patient Signature _____ Date _____

Parent or Legal Guardian Signature (for minor) _____

Relationship to the Patient _____

Signature of Treating Provider _____ Date _____

Note: Please have your legal counsel review this form before using it.