CONSENT FOR TREATMENT

Patients Name: _____ DOB: _____

I authorize and request Franco Felizarta, M.D., to provide treatment which during the course of my care as a patient is advisable. The frequency and type of treatment will be decided between my provided and me.

I understand that the purpose of these procedures will be explained to me after my verbal agreement.

I understand that if and when medication is prescribed during the course of my treatment there might be risks and side effects. These risks and side effects will be explained to me at the time. I may request at any time to stop that medication. I agree to discuss any decisions with my provider before final decisions are made.

I understand that maximum benefits will occur with consistent and compliance with treatment.

Signature: _____

Date: _____

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