Informed Consent and Authorization to Treat

King Osteopathic Medicine & Medical Acuouncture, PLLC.

I am authorizing to receive medical care and treatment as may be deemed necessary and advisable in the judgment of my physician or other medical provider for the conditions for which I present myself to this office. This may include, but not be limited to, history and physical examination, laboratory and radiology studies, Osteopathic Manipulative Therapy, and medical or surgical treatment or procedures. I understand that this authorization will be valid and remain in effect as long as I receive my medical care with King Osteopathic Medicine & Medical Acuouncture, PLLC.

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I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed of that. As in the practice of medicine, there are some risks to treatment, including, but not limited to, sprains, dislocations, fractures, disc injuries, stroke, burns, frostbite, and paralysis. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Date: _____ Patient Date of Birth: _____

Patient Name:_____

Patient Signature: _____

Name of Parent / Guardian if signing for Patient: _____

Parent / Guardian Signature: _____