PATIENT CONSENT TO TREAT

I hereby give my consent to North Dallas Primary Care Doctors, PLLC and him or her to provide my medical treatment. I understand that North Dallas Primary Care Doctors, PLLC will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize North Dallas Primary Care Doctors, PLLC 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 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 Treatment Provider:_____ Date: _____

North Dallas Primary Care Doctors, PLLC
7589 Preston Rd , Suite 600
Frisco, Texas 75034

Office: (214)705-3728
Fax: (214)308-9464
www.northdallasprimarycaredoctors.com