**CONSENT FOR TREATMENT**

I VOLUNTARILY GIVE MY PERMISSION TO THE HEALTH CARE PROVIDERS OF IMPERIAL DIGESTIVE HEALTH SPECIALISTS, PLLC AND SUCH ASSISTANTS AS THEY MAY DEEM NECESSARY TO PROVIDE MEDICAL CARE SERVICES TO ME. I UNDERSTANT THAT BY SIGNING THIS FORM, I AM AUTHORIZING THEM TO TREAT ME AS LONG AS I SEEK CARE FROM IMPERIAL DIGESTIVE HEALTH SPECIALISTS, PLLC OR UNTIL I WITHDRAW MY CONSENT.

**SIGNATURE OF PATIENT OR GUARDIAN DATE**

**PRINTED NAME OF PATIENT OF GUARDIAN RELATIONSHIP TO PATIENT**

**RESULTS POLICY**

PLEASE ALLOW BETWEEN 7 TO 14 BUSINESS DAYS FOR NOTIFICATIONS OF ALL NON-URGENT LAB RESULTS, IMAGING, PATHOLOGY, PILL CAM, AND ANY OTHER TESTING. ALL RESULTS.

ALL URGENT TESTING RESULTS WILL BE ADDRESSED AS THE DOCTOR RECEIVES THEM; PATIENT MUST FOLLOW UP IN THE OFFICE.

**SIGNATURE OF PATIENT OR GUARDIAN DATE**