GENERAL CONSENT TO TREATMENT
DOWNTOWN MEDICAL OFFICE BASED SURGERY
NY PELVIC PAIN AND MINIMALLY INVASIVE GYNECOLOGIC SURGERY P.C.
AND
NY PELVIC PAIN AND MINIMALLY INVASIVE GYNECOLOGIC SURGERY P.C.
D.B.A. NY COMPREHENSIVE GYNECOLOGY

By signing below, I, (or my authorized representative on my behalf) authorize

DOWNTOWN MEDICAL OFFICE BASED SURGERY,
NY PELVIC PAIN AND MINIMALLY INVASIVE GYNECOLOGIC SURGERY P.C., AND NY PELVIC PAIN AND MINIMALLY INVASIVE GYNECOLOGIC SURGERY P.C., D.B.A. NY COMPREHENSIVE GYNECOLOGY and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

I understand that and give consent to the above entities to receive from my health insurance plan or other third party payer information regarding my medication history.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Printed Name: _____

Signature: _____

Date: _____

Signature of ☐ Parent ☐ Guardian if patient under 18 _____

Date: _____