Windermere Medical Clinic
Canton Primary Care
Windermere Medical at Habersham
www.WindermereMedical.com

Informed Consent Form

_____ _____/_____/_____
Patient Name (Please print) Patient DOB

I, _____, authorize my Provider _____, (MD/DO/NP/PA) to perform the following test/treatment/procedure:_____

_____

By signing this form, I acknowledge and understand the following:

1. My medical condition has been explained to me by my provider.
2. The reasons for and/or the purpose of the recommended test/treatment/procedure have been explained to me.
3. The nature of the recommended test/treatment/procedure has been explained to me.
4. The risks and benefits of the recommended test/treatment/procedure have been explained to me.
5. The alternatives (including non-treatment) to the recommended test/treatment/procedure have been explained to me.
6. All of my questions about the recommended test/treatment/procedure have been answered to my satisfaction.

By signing this form, I acknowledge and 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 the test/treatment/procedure. I also understand that complications may occur which are beyond the control of the provider. Despite these risks of both known and unknown complications, I agree and consent to the test/treatment/procedure.

By signing this form, I acknowledge and understand that unforeseen conditions might arise during the test/treatment/ procedure, necessitating the performance of additional tests/treatments/procedures. I consent to the performance of any additional tests/treatments/procedures, other than those now contemplated, which my provider, his/her associates or assistants may consider necessary or advisable in the course of the test/treatment/procedure.

I have read the above consent form. I fully understand it and authorize my provider to perform the recommended test/treatment/procedure.

_____ _____/_____/_____
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

_____ _____/_____/_____
Witness Signature Date

_____ _____/_____/_____
Provider Signature