

INFORMED CONSENT FOR TREATMENT

Patient Name: _____

Medical Record Number: _____

I hereby authorize a health care provider affiliated with Body Forward to provide medical care and treatment to me for _____.

I understand that such treatment may include the administration of _____.

I understand that possible side effects of the use of _____ may include

_____. In some rare cases,
_____ may occur.

I agree that, if I experience any side effects, I will immediately contact Body Forward's providers or my primary care provider, or go to the nearest emergency room. I understand that I am ultimately responsible for ensuring that my side effects are presented to a medical professional for further diagnosis.

Before taking _____, I agree to disclose to Body Forward's providers all other medications I am using, including nonprescription medicines such as aspirin, and medicines for contraception, diabetes, appetite control, asthma or sinus problems, and all other medications.

The risks and benefits of _____ have been explained to me. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Witness

Print Name