HOPE Neurology

PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do voluntarily consent to and authorize medical care, treatment, diagnostic and therapeutic procedures by Hope Neurology, through its individual physicians, employees, and/or agents.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or Hope Neurology.

I acknowledge that I have received a copy of Hope Neurology's Notice of Privacy Practices.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____ _____

Patient Signature Patient Name (Printed)

_____

Date

Patient,_____, is a minor, or is unable to sign above because:

_____

_____ _____

Person Giving Consent Relation to Patient

_____ _____

Witness Date