

VOLUSIA OBSTETRICS AND GYNECOLOGY

500 HEALTH BLVD ~ DAYTONA BEACH, FL 32114

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CONSENT FOR TREATMENT

With any medical treatment, there is some risk involved. I hereby give consent to Volusia Obstetrics and Gynecology to provide treatment for the below mentioned patient.

_____	_____
<i>Patient/Responsible Party</i>	<i>Date</i>
_____	_____
<i>Patient/Responsible Party</i>	<i>Date</i>
_____	_____
<i>Patient/Responsible Party</i>	<i>Date</i>
_____	_____
<i>Patient/Responsible Party</i>	<i>Date</i>
_____	_____
<i>Patient/Responsible Party</i>	<i>Date</i>

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. _____ or his/her staff to examine and/or treat

Relationship

Full name of child

_____ *Responsible Party* _____ *Date*

Witness

Volusia Obstetrics & Gynecology
 500 Health Blvd, Daytona Beach, FL 32114
 Phone: 386-252-5858 Fax: 386-252-4477

**Acknowledgement of Receipt
 Notice of Patient Privacy Practices**

By signing this written Acknowledgement of receipt of Notice of Patient Privacy Practices ("Acknowledgement"), I hereby expressly acknowledge my receipt of Notice of Patient Privacy Practices.

Patient / Legal Representative Signature	Print Patient / Legal Representative Name	Date	Employee initial
Patient / Legal Representative Signature	Print Patient / Legal Representative Name	Date	Employee initial
Patient / Legal Representative Signature	Print Patient / Legal Representative Name	Date	Employee initial
Patient / Legal Representative Signature	Print Patient / Legal Representative Name	Date	Employee initial
Patient / Legal Representative Signature	Print Patient / Legal Representative Name	Date	Employee initial

Acknowledgement NOT obtained because:

_____ Patient or Legal Representative declined Notice of Patient Privacy Practices.

_____ Other (briefly describe) _____

 Employee Signature

Please list anyone with who we are able to discuss your care, finances, etc.

Name	Relationship
Name	Relationship
Name	Relationship