Complete Pulmonary Rehab

190 Aviation Plaza | Hot Springs, AR 71913 | 501.525.2770

Informed Consent

AUTHORIZATION TO TREAT

________________________________   ____________________

Patient Name   Date

I hereby give my consent and authorize treatment for therapy.

The care provider has explained my condition to me, treatment procedure(s) and alternative methods of treating my condition.

The care provider has discussed with me foreseeable risks of the above stated treatment and there may be undesirable results.

I authorize the care provider to perform any additional or different treatment which is thought necessary, should, during treatment, a condition be discovered which was not known previously.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition and the procedure(s) with the care provider. All of my questions have been adequately answered.

________________________________   ____________________

Patient Signature   Date

________________________________   ____________________

Care Provider Signature   Date