TIGARD ORTHOPEDIC & FRACTURE CLINIC

General Consent to Treatment and Right to Refuse Treatment

General Consent to treatment: By signing below, I, (or my authorized representative on my behalf) authorize Tigard Orthopedic & Fracture Clinic and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

I 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 my evaluation and/or treatment. I also understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers.

Patient Name:_____ Date of Birth:_____

AUTHORIZATION TO RELEASE INFORMATION & PHARMACY

I hereby authorize any physician, hospital, pharmacy, or medical care facility to provide all information regarding my medical or pharmaceutical history and treatment to Tigard Orthopedic & Fracture Clinic. I furthermore will allow my pharmacy to supply verification of benefits. I also authorize Tigard Orthopedic & Fracture Clinic to release my medical information to other physicians as needed to facilitate treatment.

Preferred Pharmacy: _____ City _____

SIGNATURE: _____ DATE _____