www.aitcnh.com

Patient Consent:

I, _____, authorize the providers of Advanced Injury Treatment Center to
(Patient/Parent/Guardian)
administer any treatment and perform procedures as deemed necessary in the diagnosis and treatment of
_____.
(Patient)

I realize that these procedures are to be performed by or under the direction of doctors, associates, or assistants employed by Advanced Injury Treatment Center.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the treating doctor and/or associates and assistants.

I acknowledge that no guarantee or assurance as to the results that may be obtained from procedures and treatment has been given by the treating doctor, associates or assistants.

I authorize Advanced Injury Treatment Center employees and providers to utilize my home or work numbers and answering machines, and if elected my e-mail or cell phone, for the purpose of disclosing appointment and/or treatment information.

I acknowledge that Advanced Injury Treatment Center will use reasonable means to protect the security and confidentiality of e-mail communication. However, because of the inherent risks of e-mail communication, Advanced Injury Treatment Center cannot guarantee the security and confidentiality of e-mail communication and will not be held liable for improper use and/or disclosure of confidential health information that is not caused by Advanced Injury Treatment Center's intentional misconduct.

✍ _____ _____

Signature of Patient/Parent/Guardian (Must be 18 or older) **Date**

For Parents/Guardians: By signing above, I am attesting that as of this date, I have the legal right to select and authorize healthcare services for the minor child named above. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Disclosure of Information:

If you would like us to be able to discuss and disclose your medical care and/or billing account information with anyone other than yourself, please list the name, relationship and telephone number below.

Name	Relationship	Telephone Number

Name	Relationship	Telephone Number