Riverside
OBSTETRICS
&
GYNECOLOGY

Patient Consent for Treatment

I hereby give my consent to the doctor and physician assistant at Riverside OB/GYN, P.C. to evaluate, diagnose and treat, and otherwise care for, including tests or procedures. This is a general consent for treatment for any services rendered here in the office. I understand that Riverside OB/GYN, P.C. will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Riverside OB/GYN, P.C. to perform any additional or different treatment that is thought necessary if, in an emergency, a condition is discovered that was not known previously.

I understand that payment is due at the time services are provided. I understand that I am financially responsible for all the fees, or any balance not covered by my insurance.

I have carefully read, and I fully understand this Patient Consent for Treatment.

This consent was signed by: _____
(PRINT NAME PLEASE)

SIGNATURE: _____ **Date:** _____