



**PATIENT CONSENT FOR TREATMENT**

Today's Date: \_\_\_\_\_

Time In: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize all treatment that may be considered necessary or advisable by the physician and certify that no guarantee or assurance has been made as to the results which may be obtained.

By signing you understand and agree to all of the above stated and give your consent for treatment.

Patient/Guarantor Signature X \_\_\_\_\_ Date \_\_\_\_\_

***We will be there when you need us!***

|                                                                                                              |                                                                                                        |                                                                                                       |
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| North Medford Medical Clinic<br>1600 Delta Waters Rd, Ste 107<br>Medford, OR 97504-9114<br>Tel: 541-858-2515 | South Medford Medical Clinic<br>235 Barnett Rd, Ste 106<br>Medford, OR 97501-7903<br>Tel: 541-773-4029 | Grants Pass Medical Clinic<br>162 NE Beacon Dr, Ste 103<br>Grants Pass, OR 97526<br>Tel: 541-479-1090 |
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