PEARLMED DPC, PLLC
PATIENT INFORMED CONSENT FOR TREATMENT

I, _____ (name of patient), voluntarily request and consent to Robert Wagenaar, M.D.'s ongoing primary care treatment of me as a Patient. I acknowledge that when I have sought Dr. Wagenaar's medical services and treatments, he or one of his staff has explained to me the risks and benefits that are involved in the services and treatments. I also acknowledge that Dr. Wagenaar or his staff has advised me of the alternatives, if any, that may be available. I also understand that his treatment shall entail physical medical examinations of my body, which may include urinalysis, blood tests and other primary care treatments that Dr. Wagenaar deems is medically necessary. My signature below indicates that I give permission to Dr. Wagenaar to treat me and to perform any tests and examinations that may be necessary. I understand that no warranty or guarantee has been made to me as to the results of any treatment.

I certify and agree to the following:

1. I am reading and signing this informed consent while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2. I have been given an opportunity to ask questions about my treatment and any risks and hazards involved. All of my questions have been answered to my satisfaction and I have sufficient information to give this informed consent.

3. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

Date: _____ Time: _____ A.M./P.M.

_____
Signature of Patient or Parent or Legal Guardian Date

_____
Printed Name of Patient or Parent or Legal Guardian

Witness/Physician:

Signature: _____ Print Name: _____