**Patient Consent to Treat**

I hereby give my consent to North San Antonio Family Medicine and authorize the physician and staff to provide my medical treatment. I understand that North San Antonio Family Medicine will explain my condition, foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize North San Antonio Family Medicine to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_