FAYETTEVILLE OTOLARYNGOLOGY
Head & Neck Surgery, P.A.

1839 Quiet Cove
Fayetteville, NC 28304
(910) 323-1463

Consent to Treatment

Patient _____ DOB _____ Date _____

I am a new patient at Fayetteville Otolaryngology. By signing this form, I consent to be treated by the providers of this practice.

If my doctor needs more medical facts about my health, I, _____,

ask for and allow Dr. _____

and staff to give me the needed medical treatment and services that he or she recommend.

I understand treatment and services may include:

- Lab tests
- Screening tests (tests that can find an illness early)
- Diagnostic tests (tests that show if a patient has a certain illness or health problem)
- Routine exams

I understand that no promises have been made to me about the results of any treatment or services.

_____ _____

Signature of Patient or Responsible Party | Date

_____ _____

Witness | Date