

CONSENT FOR TREATMENT

I, _____, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and special instructions of Dr. Farahmand, M.D., assistants or designee as is judged to be necessary.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatment or examination by Dr. Farahmand, M.D. I understand the potential risks and benefits of surgery include the risk of infection, bleeding, injury to nerves, postoperative stiffness and pain, and failure of the surgery to achieve its intended goals.

Procedure(s) to be performed: - _____

Signature: _____ Date: _____

Witness: _____