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DOCTORS URGENT CARE LLC
MEDICAL TREATMENT CONSENT FORM

PATIENT NAME: ______________________________________

Consent for treatment: Knowing that I (or the patient indicated on the top of this form) desire evaluation and/or treatment at Doctors Urgent Care LLC, or Doctors Urgent Care Associates LLC, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, administration of medication and to medical or surgical treatment by physicians and staff members of Doctors Urgent Care LLC and/or Doctors Urgent Care Associates LLC and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guaranties have been made to me as to the results of my examination or treatment at Doctors Urgent Care LLC or Doctors Urgent Care Associates LLC. I acknowledge that treatment at Doctors Urgent Care LLC or Doctors Urgent Care Associates LLC is intended to address specific episodic illnesses or injury and is not intended to substitute for comprehensive care in lieu of a primary care physician or other specialized physician. In order to provide the best chance for successful treatment I accept responsibility to follow the advice of my treating physician including compliance with medications, discharge instructions and re-evaluation with follow up or referral physicians. I agree to return to the clinic or seek care in an Emergency Department of a hospital if my condition substantially changes. I further agree to hold harmless the physicians and staff of Doctors Urgent Care LLC or Doctors Urgent Care Associates LLC should I fail to comply with the above conditions.

Patients at Doctors Urgent Care LLC and Doctors Urgent Care Associates LLC will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above criteria, Doctors Urgent Care LLC and Doctors Urgent Care Associates LLC reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of the physician on duty.

This consent shall remain in force until such time as it is specifically revoked.

Signature of patient or patient
representative:_________________________________Date:_________________
(Representative signature required if the patient is a minor or unable to consent)
Representative's relationship to patient:__________________________________
Patient is unable to consent because: ____
Witness:_____________________________