

# Spine Associates

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Asif M. Chaudhry, M.D.

## CONSENT FOR MEDICAL TREATMENT

**Knowing that I am suffering from a condition requiring medical care, I hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination in the hospital.**

**This form has been fully explained to me and I certify that I understand its contents.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Patient is: \_\_\_\_\_ a minor \_\_\_\_\_ unable to consent because \_\_\_\_\_

I hereby consent on his/her behalf and in his/her stead on \_\_\_\_\_

Date

Signature of Person Responsible for Patient or Patient's Legal Guardian

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Print Name