	RENEW TOTAL BODY WELLNESS CENTER **Thomas Rohde, M.D., FAAFP** **3798 E. Fulton Avenue** **Decatur, IL 62521** **217-864-2700** **www.DrRohde.com / www.RenewMyImage.com**

Consent For Treatment

Patient's Full Legal Name____

Birthdate (mo/day/year) ____/___/______ Social Security #_______________

Consent for Treatment

I am asking for, and consent to receive, care from Thomas Rohde, M.D. and other health care providers at the Renew Total Body Wellness Center. I understand this care may include 1) tests and procedures (which may include laboratory tests and X-ray examinations) and 2) medical and surgical treatment. I permit the health care providers, their associates and assistants, and their employees to provide me with services that are considered necessary or advisable.

No guarantees have been made to me about the outcome of this care. I may choose not to have recommended tests, procedures, and healthcare performed. In the event I decide to refuse the recommended treatment, considered necessary or advisable, by the health care providers I relieve Thomas Rohde, M.D. and its health care providers of all responsibility for any ill effects which might result from my action.

I acknowledge that I have read the consent for treatment and conditions listed above and further acknowledge that I am the patient or that I am duly authorized by the patient as a legal representative to execute and accept the terms as set forth herein.

2. Other

I permit a copy of this consent to be used in place of the original. This consent shall remain in effect until rescinded in writing. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to Thomas Rohde, M.D. or any of its health care providers.

If you are not the patient, please specify your relationship to the patient: ____________________

____ __________________

Signature of Patient (or Legal Guardian if Patient is a Minor) Date

____ __________________

Signature of Guarantor (Person Responsible for Payment) Date