Associates in Vascular Care

Consent for Treatment:

Patient's name: _____ Date of Birth: _____

Doctor being treated by: □ Dr. Owano Pennycooke, M.D.

□ Dr. Shelley- Ann Pennycooke, D.O.

I hereby give permission to the above named physician to provide any medical or surgical treatments on my behalf. I consent to any administration of treatments and therapies that may be deemed advisable in the judgement of the attending physician or designated associates or assistants.

Permission is also granted to provide any necessary emergency medical treatments that may be needed while being seen in the office.

I also acknowledge that I have elected on my own behalf or on behalf of my dependent to receive medical services that may or may not be covered by my health plan for any number of reasons. I understand and acknowledge that I may be financially responsible for, and therefore shall pay for, all services rendered to me or my dependent that are not paid or contractually adjusted by my insurance, in whole or in part, by my health plan for any reason whatsoever.

_____ _____

Signature of Patient or Representative *Date Consent if Signed*

Permission to Receive Recorded Messages

As a service to our patients, we provide courtesy appointment reminder or returning message calls. This authorization will permit our office staff to leave messages or appointment reminders on either your personal cell phone or house phone.

By providing your phone number you are giving authorization to *Associates in Vascular Care* to leave any messages or appointment reminders on your answering machine or voicemail box. You do not need to sign this authorization; However- if you do not sign this authorization, we will not be able to provide with any courtesy reminder calls or other important calls.

_____ _____

Signature of Patient or Representative *Date Authorization Signed*

Cell Phone Number: _____

Other Telephone Number: _____