I am a new patient at Fayetteville Otolaryngology. By signing this form, I consent to be treated by the providers of this practice.

If my doctor needs more medical facts about my health, I, [patient's name], ask for and allow Dr. [doctor's name] and staff to give me the needed medical treatment and services that he or she recommend.

I understand treatment and services may include:

• Lab tests
• Screening tests (tests that can find an illness early)
• Diagnostic tests (tests that show if a patient has a certain illness or health problem)
• Routine exams

I understand that no promises have been made to me about the results of any treatment or services.

Signature of Patient or Responsible Party                        Date

Witness                                                                 Date