Healing Hands For ADHD
Linda Caballero-Goehringer, MD
3512 State Route 257, Suite 107
Seneca, PA 16346

CONSENT TO CARE AND TREATMENT

Patient Name: DOB:

As a parent/ guardian, you have the right to be informed about the state of your child's health and any recommended medical, diagnostic or surgical procedure that will be used in the course of your child's care at this practice so that you may make informed decisions as to whether or not to undergo any recommended treatment.

If your child has been a patient of this practice prior to signing this consent, any medical conditions and/or treatment plans have already been discussed with you and you consent to the ongoing care and treatment that has been defined.

If you are a new patient with this practice, no specific treatment plan has yet to be recommended. This consent form gives us your permission to examine your child and perform the evaluations necessary to evaluate his/her health and identify any conditions that may be affecting it. It also gives your consent to recommend appropriate treatment for any conditions identified during the course of their care and treatment.

By signing this consent, you are giving us your permission to perform reasonable and necessary medical examinations and testing to assess your health and recommend treatment. You authorize this practice, your physician and any employee working under the direction of the physician to provide medical care to you. This medical care may include services related to your health and may include but not limited to preventative, diagnostic, therapeutic, maintenance, assessment or review of physical or mental status/function of the body and the prescribing of drugs or other items required to diagnose and treat a medical condition. This includes contact and discussion with other health care professionals who may be consulted regarding your care and treatment.

You are also indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully in effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the purpose, potential risks and benefits of any test ordered for you in the course of your treatment plan with your physician. If you have any concerns regarding any test or treatment recommended by your physician, we encourage you to ask questions.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Parent/Guardian Signature ___________________________________
Date: