**Right to Refuse Treatment**

In giving my general consent to treatment, I understand that I retain the right to refuse any examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

________________________________

PRINT PATIENT’S FULL NAME

________________________________

PATIENT’S SIGNATURE

________________________________

DATE