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FORM 2

Consent to Treatment

“I” collectively refers to the patient, his/her guardian and/or his/her surrogate decision maker.

I voluntarily consent to routine diagnostic procedures and medical care as deemed necessary in the judgment of my Provider(s) (including physicians, physician assistants and nurse practitioners) and whomever may be delegated assistants of any Provider(s).

I understand that this consent does not include operations or any non-routine procedures or treatments, and the risks and alternatives for such procedures or treatment which a reasonable patient would consider significant to a decision whether or not to undergo such treatment or procedures will be explained to me by my Provider(s) or another Provider(s) designated by him/her.

I realize that I have the right to refuse any drugs, treatments or procedures to the extent permitted by law.

I acknowledge that because medicine is not an exact science, no guarantees or warranties can be made to me regarding any results of any diagnostic procedures or medical treatments performed at Philadelphia Health Associates-Adult Medicine, PC.

External Prescription History

I understand that it is important for my healthcare provider to be aware of all medications that I am taking. Such knowledge will reduce incidences of drug interactions and other side effects that may occur from taking multiple drugs. If possible, I am giving permission for my health care provider to view prescription history from outside sources. **I initial here to provide consent.**_____.

Attestation

I acknowledge that I understand the above and any questions I may have had were answered to my satisfaction. **I understand that a photocopy or electronically stored copy of this signed document is as valid as the original.**

Patient/Guardian/Surrogate Decision Maker

Signature

Date