



SPORTS AND PAIN INSTITUTE OF NEW YORK

Melepura Medical Professional Corporation

CONSENT TO TREATMENT

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at Melepura Medical Professional Corporation. I am aware that the practice will treat patients regardless of race, color, age, national origin, disability or religion.

NOTE: Please read the above agreements carefully and make sure that you understand all the terms and conditions before signing below. If you do not understand, please review contents with the staff prior to signing. Your signature confirms that you have read and fully understand all the agreements, terms, and conditions above. Agreed and Accepted by:

Patient's Signature

Patient's Name

Date

Witness Signature

Febin Melepura, M.D.

Witness Name

Date