CCRH

Center for Colon & Rectal Health, Inc.

Langhorne
215-741-4910

Doylestown
215-348-7600

PATIENT CONSENT FOR TREATMENT

Name (Please print) ____

I give my consent to the clinicians and staff of the Center for Colon & Rectal Health, Inc. to perform an appropriate physical examination which may include diagnostic procedures at the time of my visit or future visits. These procedures will be explained to me at the time of my examination. Some data derived from diagnostic testing may be used for educational purposes. All information is completely anonymous.

In addition, where appropriate, therapeutic procedures may be performed to treat conditions found at the time of examination. These procedures may include the use of local anesthetics, so please make your team aware of any drug allergies. Some therapeutic procedures may include, but are not limited to, potential or expected bleeding, discomfort, a slight risk of infection, or the need for medications to be prescribed. All procedures will be explained to me at the time of my examination.

______ I agree ______ I do not agree

____ ___________________________

Patient Signature Date