

MD DIET/SERENITY MD

Patient _____ Birth date _____ Age _____
Married Single Widowed Divorced Separated

Home Address _____

City _____ State _____ Zip Code _____

Telephone # () _____ Ok to leave message: Yes No

CA Drivers Lic # _____ Email _____

Employed By _____

Business Address _____

Business Phone # () _____

Name of Spouse _____

Employed by _____

Business Address _____

Patient referred by: Sign/Drive By Friend: (name) _____ Newspaper _____

Agreement and Consent for Treatment

It is understood and agreed that I authorize and direct Roland M. Fuertez MD and/or his associates and employees to perform procedures that in their judgment are considered advisable or necessary for the patient whose name appears above. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained and the nature; purpose and risks of the procedures, and possibilities of complications have been explained to me. It is understood and agreed that any claim or dispute in connection with treatment involving the doctor and/or his associates and employees participating in my examination or care shall be settled under physician's medical insurance coverage and the patient shall not bring any claims against MD Diet/Serenity MD. Any personal accident or injury that may occur on the premises shall be settled with MD Diet/Serenity MD and no claim shall be brought against the attending physician of the program.

I hereby acknowledge this medical practice's Notice of Privacy Practices. I further acknowledge that a written copy is available to me upon request.

Date _____ Signed _____ (Patient)