

## **Authorization to Treat**

I, the undersigned patient, hereby authorize **Sholar Center for Aesthetic Surgery and Age Rejuvenation** and its staff to administer such treatment as is necessary, and to perform services and/or procedures and telehealth services as are considered necessary on the basis of findings during the course of delivery of health care services and treatment.

I hereby certify that I have read and fully understand the above Authorization to Treat, the reasons why the treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment which were explained to me.

I also certify that no guarantee or assurance has been made as to the results that may be obtained by services received at **Sholar Center for Aesthetic Surgery and Age Rejuvenation**.

Print Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

### MINOR CHILD AS PATIENT:

I acknowledge the above and agree. I also approve that my child can receive services as ordered in the event I am unable to accompany them to the daily treatment. I am aware that a parent or guardian must be present for examinations and evaluations by the professional staff as well as for any report of findings or treatment progress visits.

Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_