DOXOLOGY
HEALTH & FERTILITY

Consent for Treatment of Adult

I (the patient) hereby consent to the administration of health care by Doxology Health and Fertility, LLC (DHF). Health care may include care, treatment, services, examinations, tests, consultations, or procedures to diagnosis or treat me (the patient). This Consent for Treatment shall specifically include tests for the presence/absence of alcohol or controlled substances and infection, such as HIV, Hepatitis, gonorrhea, chlamydia or syphilis. I acknowledge by signing below that I am giving my consent to the administration of health care by DHF voluntarily, and that I hereby knowingly and voluntarily enter into this Consent for Treatment. I have been informed and understand that I may withdraw my consent for treatment at any time by providing written notice to DHF.

Consent for Treatment of Minor

I am the (circle one) parent/guardian/custodian/legally authorized representative of _____, an unemancipated minor child who is _____ years of age (hereafter the "Patient") and I have authority to execute this Consent for Treatment on behalf of the Patient. I hereby consent to the administration of health care by Doxology Health and Fertility, LLC (DHF) for the Patient. Health care may include care, treatment, services, examinations, tests, consultations, or procedures to diagnosis or treat the patient's condition. The conditions or limitations, if any, on my consent and the authority delegated to DHF hereunder include: _____. The consent for Treatment shall specifically include tests for the presence/absence of alcohol or controlled substances and infection, such as HIV, Hepatitis, gonorrhea, chlamydia, or syphilis. I acknowledge by signing below that I am giving my consent to the administration of health care by DHF for the Patient voluntarily, and that I hereby knowingly and voluntarily enter into the Consent for Treatment. Due to the Patients' inability to sign this Consent for Treatment, I hereby agree on behalf of the Patient, and to bind the patient to the terms of this Consent for Treatment. I have been informed and understand that I may withdraw my consent for treatment at any time by providing written notice to DHF.

Responsible Party (print) _____ Date _____

Signature _____

Relationship to Patient _____