Pagelopolus Endocrinology

Form 01 - General Consent to Treat

Document version: 2026-02-26

Patient full name: _____ Date of birth: _____
Medical record number: _____ Date: _____

Consent for Evaluation and Treatment

I authorize Pagelopolus Endocrinology and its clinical team to provide routine evaluation, diagnosis, and treatment within the scope of endocrine care.

I understand:

1. No specific outcome can be guaranteed.
2. I may ask questions and receive explanations in understandable language.
3. I may withdraw consent for future treatment at any time.

Patient initials: _____

Communication Authorization

I authorize the clinic to communicate with me by:

- Phone: Yes / No
- Voicemail: Yes / No
- SMS: Yes / No
- Email: Yes / No
- Patient portal: Yes / No

Preferred contact number/email: _____

Patient initials: _____

Financial Responsibility Acknowledgment

I understand I am responsible for charges not covered by insurance and for charges related to complications requiring additional care.

Patient initials: _____

Signatures

Patient or legal representative name: _____ Relationship (if not patient): _____ Signature: _____ Date: _____

Witness/staff name: _____ Signature: _____ Date: _____