CONSENT FOR TREATMENT FORM

I, _____, of sound mind hereby consent and grant permission to my physician, Tuan M Vo DO and other staff at Sunrise Family Medicine PLLC to participate and treat my medical condition and address my medical concerns within the standard of care of Osteopathic Family Medicine and associated complimentary and integrative medicine practices that may include but are not limited to: review of my medical history, clinical exam, laboratory testing, imaging, as well as Osteopathic Manual Therapy, Medical Acupuncture and other approved therapies that fall within the practice of the treating physician. I further understand and accept the risks, benefits of such treatment for my medical care. I understand and accept these risks and release Dr. Tuan M Vo DO and any of his staff at Sunrise Family Medicine PLLC from all liability should any unanticipated adverse events occur during my treatment with the expectation that treatment will proceed in good faith and professional manner to the highest standard of care. Dr. Tuan M Vo DO and his staff, will do their best to maintain to the best of their ability my safety, integrity, do what is in my best interest to better my health and help care for my mind and body.

Patient Name: _____

Date: _____

Acknowledged by Sunrise Family Medicine PLLC Staff:

_Tuan M VO DO_____

Date: _____