



PATIENT INFORMED CONSENT FOR TREATMENT AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

---

**PELVIC/RECTAL EXAMINATION INFORMED CONSENT:** The undersigned understands that the physical examination may include a medically appropriate examination of his/her pelvic area, and/or rectum and he/she consents to such examination.

**GENERAL TREATMENT CONSENT:** The undersigned has voluntarily presented for medical care and consents to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary or appropriate for the purpose of diagnosis. Procedures or exams may include, but are not limited to anoscopy, breath tests, capsule endoscopy, fibroscan, hemorrhoid banding, ultrasound, and rectal exam. The undersigned understands that the nature of, intended purpose, potential risks/complications, and alternatives for each procedure or treatment will be explained to him/her beforehand. The undersigned understands and acknowledges that no warranty or guaranty has been or will be made as to the result or cure of treatment.

**Notice of Privacy Practices Acknowledgement:** The undersigned understands he/she has a right to review the Provider's Notice of Privacy Practices prior to signing this document and acknowledges that the Provider's Notice of Privacy Practices has been provided to him/her. The Notice of Privacy Practices for the Provider is also provided in the waiting room.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority