CONSENT TO TREATMENT

The policies and practices of Esther Samadi, M.D., are described in the document, "Office Policies and Practices 2022." You have been given a copy of "Office Policies and Practices 2024" for review. The purpose of this form is:

1. For you to give your consent, in writing, to receive services from Esther Samadi, M.D.; or
2. If you are consenting on behalf of your child, for you to give your consent, in writing, for your child to receive services from Esther Samadi, M.D.

I/We understand the following:

- That our decision to seek services from Esther Samadi, M.D. is voluntary. I have read the document entitled, "Office Policies and Practices 2024," and I understand the policies and procedures detailed in it. I agree to adhere to the policies and procedures detailed in this document and I consent to receive services from Esther Samadi, M.D.
- That I/we have been fully informed about the nature, risks and benefits of treatment, and the availability of treatment options.
- That I/we have had the opportunity to have all questions answered to my/our satisfaction.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent for this treatment at any time.
- That Dr. Samadi may receive professional consultation with regard to patient care. I consent to have Dr. Samadi disclose my private information to consultants and colleagues for the purpose of professional consultation.

Please sign below to indicate that you agree with all statements above and that you consent to receive services from Esther Samadi, M.D.

Signature _____ Date _____