MD DIET/SERENITY MD

Patient_____Birth date_____Age_____

☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

Home Address_____

City_____State_____Zip Code_____

Telephone # ( )_____ Ok to leave message: ☐Yes ☐No

CA Drivers Lic #_____Email_____

Employed By_____

Business Address_____

Business Phone # ( )_____

Name of Spouse_____

Employed by_____

Business Address_____

Patient referred by: Sign/Drive By Friend: (name)_____ Newspaper _____

Agreement and Consent for Treatment

It is understood and agreed that I authorize and direct Roland M. Fuertez MD and/or his associates and employees to perform procedures that in their judgment are considered advisable or necessary for the patient whose name appears above. I acknowledge that no guarantee, refund or assurance has been made as to the results that may be obtained and the nature; purpose and risks of the procedures, and possibilities of complications have been explained to me. It is understood and agreed that any claim or dispute in connection with treatment involving the doctor and/or his associates and employees participating in my examination or care shall be settled under physician's medical insurance coverage and the patient shall not bring any claims against MD Diet/Serenity MD. Any personal accident or injury that may occur on the premises shall be settled with MD Diet/Serenity MD and no claim shall be brought against the attending physician of the program.

I hereby acknowledge this medical practice's Notice of Privacy Practices. I further acknowledge that a written copy is available to me upon request.

Date_____Signed_____ (Patient)