Cascadian Plastic Surgery PLLC
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14 N Mission St Ste 201
Wenatchee, WA 98801
(509) 596-0096

CONSENT FOR TREATMENT

Cascadian Plastic Surgery, PLLC

I, _____, consent and authorize Cascadian Plastic Surgery PLLC ("Practice") to provide general medical and surgical care as indicated by the physicians, nurse practitioners, and physician's assistants of the Practice.

I understand that:

- I have the right to be involved in my care including the legal right to refuse any procedure or treatment.
- I have the right to be informed of the care being given and to discuss the medical treatments recommended for me with my clinical team.
- I have the right to be informed of the potential risks and benefits of a medical treatment recommended for me and possible alternative treatments.
- I may be asked by the Practice's providers to give additional informed consent for specific services and procedures.
- No guarantees or promises have been made to me by the Practice or its providers with respect to the results of the medical care and treatment rendered by the Practice's providers to me.

_____ _____

Patient Signature Date