L. Scott Stoney, M.D. ***CALIFORNIA REHABILITATION, INC.
Physical Medicine and Rehabilitation

361 Hospital Rd, Suite #425
Newport Beach, CA 92660
(949) 548-4580

CONSENT FOR TREATMENT

I authorize and direct my physician, their associate, or medically authorized representative to render therapeutic procedures or treatments that in their medical judgments may be advisable for my wellbeing. The risks, possible alternatives and possible complications along with the nature of the treatments and procedures have been explained to me to my satisfaction. No warranty or guarantee has been made as to the end results of my care.

I know that no services will be rendered to me without the review and signing of the legal arbitration agreement and consents for treatment and being signed and dated, prior to receiving those services.

California Rehabilitation maintains medical personnel and facilities to assist your physician and surgeons in the performance of various medical and surgical procedures. There treatments may involve the possibility of unsuccessful results to include complications, disability, injury or even death from both known and unknown causes, from both see and unforeseen causes. No warranty is made or implied as to the guarantee results or cure. You may have the right to be informed by your physician as to the risks as well as the nature and purpose of the treatment and the available alternative methods of treatments. Except in cases of emergency, operations or procedures are not performed until the patient has the opportunity to receive all pertinent information and explanations. You have the right to obtain a second opinion or to refuse any proposed treatment or procedure.

Your physician, Dr. Stoney, has recommended, or will be recommending, treatments during your course of care. These treatments and procedures will be performed by supervising physician and surgeon named above or his designee together with associates and assistances form the medical staff of California Rehabilitation, Inc. In the event of an emergency, I hereby authorize California Rehabilitation, Inc. to provide medical care through their office, utilizing the authorized office staff as well as appropriate personnel from hospital facilities.

YOUR SIGNATURE BELOW CONSTITUTES YOUR ACKNOWLEDGEMENT AND CONSENT:

A. I HAVE READ AND AGREE TO THE POLICIES, CONDITIONS AND THE INFORMED CONSENT
B. I WILL REQUEST ALL DESIRED INFORMATION CONCERNING MY TREATMENT, CARE AND BILLING YOU RECEIVE THROUGH CALIFORNIA REHABILIATION, INC.

Today's Date: _____/_____/_____ **_____**

Patient's printed name in full

Patient or responsible party's signature