

MEMORIAL NEUROLOGICAL ASSOCIATION

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Medical Neurology
Electromyography
Electroencephalogram
Evoked Potential
Duplex Neurosonology
Neuropsychology
Neuroimaging
IDD Therapy
VNG Testing
Balance Training

PATIENT # _____

CONSENT FOR TREATMENT

I, _____ authorize and direct Memorial Neurological
(patient's name)

Association and _____ to perform upon me general and
(name of physician)

neurological exams and/or any other procedure in his/her judgment determined advisable for my well being.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the outcome of procedures and/or treatment.

Patient
Signature _____ Date _____

Witness _____ Date _____

IF PATIENT IS A MINOR OR UNABLE TO SIGN:

Signature of
Responsible Party _____ Date _____

Relationship to
Patient _____

Witness _____ Date _____