2924 Swede RoadP: (484) 370-8140
East Norriton, PA 19401

F: (484) 370-8135
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Consent for treatment

Consent for treatment: I authorize Artery and Vein Institute, LLC (AVI) and its physicians and staff to provide any necessary treatment and procedures for the patient, as determined by the attending physician, Joseph Grisafi. Photographs, video recordings, or audio may be utilized during my appointment or treatment for the purpose of ensuring my safety. Photos may be included in my medical records as needed. I acknowledge that no guarantees have been made as to the results of treatment or examination at AVI, or otherwise. I understand that I have the right to refuse any drugs, treatment, procedure, or photographs to the extent permitted by law.

Patient name ____Date of birth ____________

Acknowledgement: I certify that I have read this document, that it has been explained to me and I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge that receipt of a copy will be granted if requested.

Patient Signature ____ Date ________________