

Piedmont Internal Medicine, Pulmonary And
Infectious Diseases, PA.

Informed Consent of Services

Patient Name: _____

File Number: _____ **Date:** _____

I have been informed about the test and/or treatment I am about to receive. I hereby give Piedmont internal Medicine, Pulmonary and Infectious Diseases, PA. the consent to perform this test and/or treatment on this date. I realize and understand that I have the right to refuse this test and/or any part of the test at any time.

Patient Signature: _____ **Date:** _____

Witness: _____

Consent to Videotaping

I have been informed about the procedure of videotaping during testing. I hereby give my consent to videotape the procedure if the technician determines that this is necessary for obtaining accurate test results. It has been explained to me that should no occurrences are present pertinent to test; the video tape will be appropriately erased for future use.

Patient Signature: _____

Witness: _____

By not signing any or all parts of this consent form, patient assumes the responsibilities of the decision not to give consent.