



Consent to Treat, Notice of Privacy Practices and Patients' Rights and Responsibilities

I give permission for Nebraska Cancer Specialists (NCS) to render to me medical treatment. I also understand I have the right to refuse any procedure or treatment and to discuss all medical treatments with my provider.

My signature below acknowledges that I have been offered the Notice of Privacy Practices and Patient Rights and Responsibilities (a copy is available at the office upon request).

(Signature of patient or legal guardian)

(Date)

(Printed name of patient)

(Printed name of legal guardian)

(Witness)

(Date)