



Saint Louis  
GYNECOLOGY & ONCOLOGY

## CONSENT FORM

The following information is to be completed by the patient, or the patient's legally authorized representative/parent.

I, \_\_\_\_\_, consent to medical treatment by Dr. Elbendary or his designee, for myself or for the patient for whom I am the parent or legally authorized representative. I acknowledge that no guarantees have been made to me as a result of medical treatments, diagnostic procedures or examinations.

In order to induce the physician to see the patient in Illinois with respect to medical services otherwise to be provided by physician in St. Louis County, Missouri, patient hereby agrees that all actions or proceedings against physician shall be litigated only in courts (State or Federal) having situs in the State of Missouri and the County of St. Louis unless physician, in his sole discretion, waives this provision. Patient hereby expressly submits and consents in advance to such jurisdiction in any such action or proceeding.

\_\_\_\_\_  
Signature of Patient (or legal guardian/representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date