**NYC Psychiatry & Primary Care Physicians**
also DBA DOCTOR IN THE FAMILY formerly New York House Call Physicians
*Updated by Natan Schleider, M.D. February 5th, 2021*

# *DECLINE TESTING AND OR CONSULTS AND OR TREATMENT FORM FOR PATIENTS*

I_____ decline and refuse any recommended testing, consults, and or treatments advised and or scheduled today or in the past which I have not gone for. The benefits and risks of advice for testing, consults, and or treatment have been reviewed with me.

My signature below indicates I feel the risks of the advised testing, consults, and or treatment exceed the benefit. I understand by signing below I may be refused medical care in the future by DOCTOR IN THE FAMILY.

**Patient Name:**_____

**Patient Address:**_____

**Patient Telephone &/or Cell Phone:**_____

**Patient Date of Birth:**_____

**Patient Email**_____

**Patient or Guardian Signature:**_____

**Today's Date & Time:**_____

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