MedicalMutual
INSURANCE COMPANY OF MAINE

Informed Refusal Form

Patient

Patient Name: _____ Date of Birth: _____

Medical Record Number (if applicable): _____ Date of Refusal: _____

Healthcare Provider

Provider Name: _____ Contact Number: _____

Facility/Clinic Name: _____

Treatment/Procedure Recommended

I, _____ **(patient's name)**, have been advised by my healthcare provider to undergo the following treatment(s) or procedure(s):

Recommended Treatment/Procedure: _____

Reason for Recommendation: _____

Risks and Consequences of Refusal

I understand that by refusing the recommended treatment/procedure, I may experience the following risks and consequences, which have been explained to me by my healthcare provider:

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Patient Acknowledgment

I acknowledge that:

- My healthcare provider has explained the recommended treatment/procedure, including its risks, benefits, and alternatives.
- I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.
- I understand the potential consequences of refusing treatment, including worsening of my condition, potential disability, or even death.
- I am making this decision voluntarily and without coercion.

Patient (or Legal Representative) Signature

I hereby refuse the recommended treatment/procedure, fully understanding the possible consequences.

Patient/Legal Representative Name: _____

Signature: _____ Date: _____

Healthcare Provider Statement

I have explained the recommended treatment/procedure, its risks, benefits, and alternatives to the patient. I have also explained the potential consequences of refusing treatment. The patient (or legal representative) has demonstrated understanding and has chosen to refuse treatment.

Healthcare Provider Name _____

Signature: _____ Date: _____