

**HUGHES CENTER FOR AESTHETIC MEDICINE  
1765 S. SRINGDALE ROAD, SUITE B-2  
CHERRY HILL, NJ 08003  
856-751-4554**

**Consent: Conditions of Treatment**

**MEDICAL AND SURGICAL CONSENT FOR HUGHES CENTER FOR AESTHETIC MEDICINE:** The undersigned consents to any x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment or post-operative hospital services rendered under the general and special instructions of the medical provider performing the procedure.

The undersigned recognizes that the anesthesia provider who may furnish services to the patient are independent contractors and are not employees or agents of Hughes Center for Aesthetic Medicine.

The undersigned certifies that he/she is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Patient's Agent or Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date of Signing

\_\_\_\_\_  
Time: Hour/Minutes/AM-PM

\_\_\_\_\_  
Witness

\_\_\_\_\_  
If translation required, Signature of