[Clinic Name]
[Clinic Address]
[Phone Number]
[Date]

Informed Consent for High-Dose Treatment

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Treatment Type: [Specific Medication/Procedure]

I, [Patient Name], hereby authorize Dr. [Physician Name] and the clinical staff to administer the high-dose treatment mentioned above. I acknowledge that I have been informed of the following:

- **Purpose:** The clinical necessity for a dosage exceeding standard levels to treat [Medical Condition].
- **Risks:** Potential side effects and complications associated with high-dose therapy, including but not limited to [List Side Effects].
- **Benefits:** The expected clinical outcomes and goals of this treatment plan.
- **Alternatives:** Standard dose options and other available treatments, including the risks of non-treatment.

I understand that medicine is not an exact science and that no guarantees have been made regarding the results of this treatment. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

By signing below, I voluntarily consent to this high-dose treatment.

_____
Patient/Guardian Signature

_____
Date Signed

_____
Witness/Physician Signature