General Consent for Care and Treatment Consent

This consent provides us with your approval to perform necessary medical examinations, testing and treatment. By signing below, you are signifying that:

(1) My consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner), and other health care providers under the supervision of a physician, as considered essential and reasonable.
(2) You expect that this consent is ongoing in nature even after a specific diagnosis has been made and treatment options are suggested.
(3) I am informed that the practice of medicine is not an accurate science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations.
(4) I agree and acknowledge that this practice is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient.
(5) The consent will remain completely effective until it is revoked in writing. You have the right at any time to terminate services. You have the right to review and discuss the treatment plan with your healthcare provider about the purpose, possible risks and benefits of any test ordered for you. I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner,), and other health care providers or as deemed necessary, to perform reasonable and required medical examination, testing and treatment for my medical condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I confirm that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

FOR TELEHEALTH: I understand that telemedicine (obtaining health information via electronic communications for the health of the patient, including consultation, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be confined to authorized recipients in accordance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the suggested medical surgical and or diagnostic procedure to be utilized so that you may make the decision whether or partake or refused any suggested treatment plans or procedure after understanding the risks, dangers and benefits involved. At this point in your care, no specific treatment plan has been recommended. This consent form serves your permission to perform the required evaluation to recognize the appropriate treatment and/or procedure for any recognized health condition(s).

Patient/Guardian Printed Name _____ Date _____

Patient/Guardian signature_____ Date_____

Name of Witness _____ Date_____