

# Consent for General Care and Treatment



As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure(s) to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or physician assistant, or their designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the 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 tests(s) or procedure(s).

***I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.***

**Patient name:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Signature:** \_\_\_\_\_  
*(Patient or authorized representative)*

**Today's date:** \_\_\_\_\_

**Authorized representative information, if applicable:**

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_  
*(Spouse, caregiver, etc.)*