General Consent for Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may decide whether or not 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 the 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 other 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 provider 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, dentist, advanced practitioner (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical/dental 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 before the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

I acknowledge that under the Health Insurance Portability and Accountability Act (HIPAA) Carolina Family Health Centers, Inc. (CFHC, Inc.) is authorized to release my medical records to other healthcare specialists or entities to carry out treatment, obtain payment or conduct certain healthcare operations.

To comply with the Health Insurance Portability and Accountability Act (HIPAA), CFHC, Inc. must obtain authorization from the patient before detailed messages are left for the patient or before speaking with anyone else on the patient's behalf. This policy is to protect patients and the staff of CFHC, Inc. If there is not a signed consent on file, providers and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

➢ ________ I give CFHC, Inc. staff permission to leave messages regarding scheduling, treatment, lab or radiology results or other necessary information and/or speak with specified individual on my behalf as indicated below:

With _________________________ Relationship _________________________

With _________________________ Relationship _________________________

- _____ I agree to be responsible for my co-payments, deductibles or other charges for services not covered or paid by insurance or other third party payers. I authorize CFHC, Inc. to file any claims to my insurance if applicable for payment of any portion of my bill and assign all rights and benefits to CFHC, Inc. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event CFHC, Inc. takes action to collect the same because of my failure to pay in full all incurred charges.

PARENTS/LEGAL GUARDIAN ONLY:

- _____ The following person(s) has my permission to bring my child for treatment in my absence. This individual has the authority to make medical decisions on my behalf. If the provider does not feel comfortable providing treatment, the treatment may be withheld until the provider can speak to a parent or legal guardian.

  Name ______________________________ Relationship to Patient ________________

  Name ______________________________ Relationship to Patient ________________

  Name ______________________________ Relationship to Patient ________________

  Parents' Contact Number: ____

This document is effective for one year unless withdrawn in writing.

______________________________ ____________ _______________

Patient's Name (printed) *DOB* *MR#*

______________________________ ________________________

Patient/Parent / Legal Guardian's Signature *Date Signed*
(Parent must sign for minor child)

______________________________ ______________________

Witness' Signature *Date Signed*