EMPOWERED ENDINGS

Dignity Through Every Chapter

CONSENT FOR CARE AND TREATMENT

TO OUR VALUED PATIENTS: You have the right, as a patient, to be informed about your condition and the recommended medical care and/or diagnostic procedure or treatment to be used, so that you can make the decision whether or not to undergo any suggested care, treatment or procedure after knowing the expected benefits as well as the risks and hazards involved. At this point in your care no specific treatment plan has been recommended. This consent form is simply an e ort to obtain your permission to perform ff the evaluation necessary to identify the appropriate treatment(s) 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 your place of residence, or at our office location in San Diego. 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 healthcare provider(s) about the purpose, potential risks and benefits of any test and/or treatment recommended for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider(s) we encourage you to ask questions.

“I voluntarily request a physician, and/or mid level provider (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 examinations, testing and treatment for the condition which has brought me to seek care with this practice. I understand that if additional testing, treatments or procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s), treatment(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’s Name*

Date of Birth*

Signature of patient or Responsible Party*

Relationship to Patient*

Date*