GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: The Florida Medical Consent Law, Chapter 766.103 of the Florida Statutes, requires any person undergoing procedures and treatment shall be informed in general terms of the following:

1. A general understanding of the procedure(s) and or course of treatment or care provided in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained;

2. Medically acceptable alternative procedures or treatments, including no treatment; and

3. Risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; and Accordingly, you have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, there may not be a specific treatment plan 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 your residence or other mutually acceptable location that is conducive to the proposed treatment and/or procedures. 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 other physician or health care providers 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 healthcare provider, we encourage you to ask questions.
I voluntarily request a physician, and/or mid-level provider (e.g., Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist, Medical Social Worker, etc.), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care from Gift of Health Medical. I understand that if additional testing or procedures are recommended, I may be asked to read and sign additional consent forms prior to 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 no guarantees have been made to me as to the effect of such examinations or treatment and that I am responsible for all reasonable charges, if any, in connection with the care and treatment rendered.

_____ Signature of Patient or Personal Representative

_____ Date

_____ Printed Name of Patient or Personal Representative

_____ Relationship to Patient

_____ Signature of Witness

_____ Date

_____ Printed Name of Witness