GENERAL PATIENT CONSENT FOR CARE FORM

Patient Name__________________________ DOB______________________

General Consent to Care

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Albemarle Family Foot & Ankle on an outpatient/ office visit basis.

I authorize the facility to contact healthcare providers from whom I have received treatment to obtain medical information and/or records, including but not limited to, commercial pharmacies for verification of my medications.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Albemarle Family Foot & Ankle.

Telemedicine

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

To the Patient

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure(s) 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, 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).

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 recommend by your health care provider, we encourage you to ask questions.

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. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent

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

____ ______________________

Signature of Patient (or Responsible Party) Date

Printed Name of Patient or Responsible Party ______________________________________

Relationship to Patient____