Trinity Health
Heidi Efinger NP-C

GENERAL CONSENT FOR TREATMENT

NAME: _____ **DOB:** _____

ADDRESS: _____ **EMAIL:**_____ **PHONE:** _____
_____

GENERAL CONSENT FOR TREATMENT

I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, radiology, laboratory procedures and medicaton administration

I understand that excluding emergency or extraordinary cirsumstances, no substantial procedures will be performed without providing me an opportunity to give informed consent for that procedure. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment. This understanding includes that no research or experimental procedures may be done without my knowledge and consent.

RELEASE OF MEDICAL INFORMAITON

This form has been fully explained to me, and I understand its content and significance. I consent to Trinity Health's use of my health information related to the medical services and for health care operations of Trinity Health or other treating proviers, all as permitted under federal and state laws and regulations.

PAYMENT

In consideration of the health care services provided to me, I agree to pay all charges in a timely manner.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Signature of Patient: _____ **Date:** _____