General Consent to Treatment

Patient Name:_____________________________ Date of Birth:________________Date:________________________

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 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).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. You may be prescribed medications, injections, therapies, counseling, health advise/recommendations and/or alternative options for the problem(s) for which you came. You may be offered telehealth services for certain treatments. Telehealth is a mode of delivering health care services, via communication technologies (e.g., Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and you consent to treatment at Southeast Regional Pain Center.

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 physician or provider about the purpose, potential risks and benefits of any test ordered for you. If you have concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

Your signature indicates that you 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 examination, testing and treatment for the condition which has brought you to seek care at this practice. If additional testing, invasive or interventional procedures are recommended, you may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

We at Southeast Regional Pain Center will make every effort to explain and describe in detail your individualized plan of care. By signing below, you acknowledge that you will be clear in requesting information about all aspects of treatment when experiencing feelings of uncertainty or the need for additional information. Your signature will authorize Southeast Regional Pain Center to request protected health information from outside physician practices and hospitals that have previously participated or are currently participating in your healthcare.

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

Patient Printed Name:____ Patient Date of Birth:________________

Patient/Legal Representative Signature: ________________________________ Date: ________________________