DEWITT
FAMILY PRACTICE

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services, and if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

OGH/DEWITT encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The clinic cannot assume the responsibility for payment of medical care received outside this clinic, i.e, surgical procedures.

DISCLAIMER ON SCREENING: Among its services, the clinic utilizes screening tests, which are a method of identifying individuals who are at risk for developing several common medical problems. In this way they can alert you to promptly seek medical evaluation and treatment from a private physician of your choosing. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases and they may miss some cases of diseases they are intended to find. They are not diagnosed and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the clinic, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injection, medications, other treatments, and render other health services to the patient identified on this form.

INFORMED CONSENT: In addition to the above general consent, I understand that special informed consent forms must be read and signed. This statement may inform the client that communicable disease information will be reported as is required by law, irrespective of client consent.

I certify that this form has been fully explained to me, that any blank lines have been filled and that any questions I have had about the services have been answered to my satisfaction.

Patient Name: _____ Date: _____

Signature: _____

Relationship (if under 18): _____

I HEREBY GRANT PERMISSION TO THE AUTHORITIES OF OCHILTREE HOSPITAL DISTRICT AND THE MEDICAL STAFF TO PERFORM SUCH MEDICAL AND OR SURGICAL PROCEDURES THEY MAY DEEM NECESSARY, UNDERSTANDING THE SAME AND CERTIFYING THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED AND TO RELEASE SUCH INFORMATION CONTAINED IN THIS REPORT TO THE ATTENDING PHYSICIAN OR COMPANY PHYSICIAN OR INSURANCE COMPANY AS NECESSARY FOR COMPLETION OF HOSPITAL CLAIMS. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO OCHILTREE HOSPITAL DISTRICT OF ANY HOSPITAL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE DISTRICT OF ALL CHARGES, NOTWITHSTANDING ANY BENEFITS THAT MIGHT BE PAYABLE BY HOSPITAL INSURANCE.

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

3. Please print the address of where you would like your billing statement and/or correspondence from our office to be sent if other than your home.

4. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number.

5. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine, voicemail? Or with anyone who answers your home phone? YES _____ NO _____

Patient Name (Guardian if under 18): _____

Patient/ Guardian Signature: _____ Date: _____

GENERAL CONSENT/PROCEDURE CONSENT FORM

I, _____, on this date, _____,
Patients Full Name *Date of Procedure*

understand that I am having the following procedure: _____
Name of Procedure

for the following reason: _____.
Reason for Procedure

I understand that there are risks with any medical procedure and these are as follows:

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I, _____ acknowledge these risks and authorize, OGH/PHC/DEWITT, M.D. to
Patients Full Name

perform this procedure.

_____ _____
Signature of Patient/Guardian of Patient *Date Signed*

_____ _____
Person Obtaining Consent/Witness *Date Signed*