Prima CARE P.C.

Consent to Treatment

Prima CARE P.C. requires each patient (or an authorized representative) to sign this Consent to Treatment form prior to receiving examination, care and treatment from a Prima CARE provider. An "authorized representative" may be a parent, legal guardian, or Health Care Proxy.

Patient Name:	Date of Birth:

By my signature below, I voluntarily consent to examination, care and treatment by Prima CARE health care providers and/or their designated assistants (Prima CARE Staff).

I understand that in the course of caring for me, Prima CARE Staff may discover conditions that may require additional testing, procedures, treatments and/or referrals that were not initially planned. I hereby authorize Prima CARE Staff to perform such additional testing, procedures and/or treatments, and make such referrals, that are advisable in their medical judgment. I consent to medical photographs being placed into my medical record. I understand that if certain testing, procedures or treatments are recommended, I will have an opportunity to discuss the treatment plan with my provider and I will be asked to read and sign additional specific consent forms prior to receiving such test(s), procedure(s) and/or treatments.

I impose no specific limitations or prohibitions regarding examination, care and treatment other than those listed here (if any):

_____

_____

I acknowledge that no guarantees have been made to me as to the effect of any examination, care or treatment performed by Prima CARE Staff. Any questions I have about this Consent to Treatment Form and its contents have been answered to my satisfaction.

Signature of patient:	Date:	Time:

If patient is an unemancipated minor, incapacitated (physically or mentally), or if patient signs with a "mark", signature & witness(es) required below:

Signature of Personal Representative (parent, legal guardian, Health Care Proxy): _____

Relationship to Patient/Legal Authority: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____
Physician/nurse or health care professional

Second Witness: _____ Date: _____ Time: _____
Required if phone or verbal consent or if patient mark

Contact in case of an emergency:

Name: _____ Relationship to patient: _____

Phone: _____
Circle one: Cell / Work / Home

Created May, 2019
Revised June, 2019