El Centro de Corazón

Consent for Treatment

Name of client: _____ **Date of Birth:** _____/_____/_____ **MRN** _____

I acknowledge that I am seeking medical services and I hereby and voluntarily consent to authorize the physicians, midlevel providers (Physician Assistant, Advance Practice Nurse, Certified Nurse Midwife), dentists, Behavioral Health Providers, and El Centro staff at their service locations to provide health care services to me. The health care services may include routine physical and mental assessment, diagnostic and monitoring tests and procedures, examinations and medical and/or dental treatment, if available. The health care services may include, but are not limited to, routine laboratory work, such as blood, urine and other studies, x-rays and other imaging studies, heart tracing (EKG), administration of medications, as well as procedures and treatment prescribed by the medical and/or dental staff. The health care services also may include counseling services necessary to receive appropriate services including family planning services as defined by federal regulation.

I hereby consent to the diagnosis and treatment of any infectious, contagious or communicable disease that is required to be reported.

I hereby consent to the examination and treatment for drug or chemical addiction, drug or chemical dependency or any other condition directly related to drug or chemical use.

I consent to counseling by a medical, dental, or mental health provider for sexual, physical, or emotional abuse, suicide prevention, or chemical addiction or dependency.

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and will receive a Vaccine Information Statement (VIS) for each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that there are no guarantees being made to me concerning the results of the treatment provided or the effectiveness of any birth control methods prescribed for me.

I authorize the El Centro de Corazón to release medical, behavioral health, and dental information to third party insurance carriers for the purpose of filing insurance claims related to my care.

I have received the *HIPPA notification* and *Patient and Center Rights and Responsibilities* and the *Notice of Patients Privacy Rights* and understand my rights as stated in those documents.

I certify that I fully understand this consent for treatment, use of midlevel providers, release of personal health information and my rights concerning these issues.

I understand that this consent is valid and remains in effect as long as I am a patient of El Centro de Corazón.

I have been given an opportunity to ask questions about the services to be provided by El Centro and I believe that I have sufficient information to give this consent.

For unaccompanied minors

A **Minor** is an individual who is under 18 years of age who is not and has not been married or had the disabilities of minority removed by the court.

I am qualified to give consent for my treatment based on the following:

☐ I am on active duty with the United States Armed Services
☐ I am 16 years of age or older, residing separately and apart from my parents, or guardian, and managing my own financial affairs
☐ I am unmarried and have gone longer than 4 weeks without a menstrual cycle
☐ I am seeking diagnosis and treatment for a communicable disease or a condition related to drug or alcohol dependency
☐ I am unmarried and have custody of my child and give consent for my child's medical care

I hereby *(check one or other)* □ **do** □ **do not** consent to my physician or midlevel provider advising my parents or guardian concerning the treatment given to or needed by me. My parent or guardian name(s) _____.

_____ _____
Signature of patient, parent, legal guardian if patient is a minor or **Non-parent adult

Witness (Staff)

_____ _____
Print Name

Print Name

_____ _____
Date Time

Date Time

**Supporting documentation form completed & attached. Staff name print: _____ Staff signature _____