



General Consent for Care and Treatment Consent

TO THE PATIENT: 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. Treatment includes medications currently authorized or approved by the US FDA for treatment of COVID 19 or other emerging communicable respiratory illnesses. Testing includes, but is not limited to physical, radiological, and laboratory testing. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. 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 about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I 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, taking of photographs of my condition and treatment for the condition which has brought me to seek care at this practice.

I consent to allow my laboratory testing specimens (including, but not limited to blood, urine, or sputum samples) to be processed in-house (by MSCC/lab) or sent out to a reference lab as deemed necessary by Midway Specialty Care Center, Inc. I also understand that my specimens may be used for validation purposes.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

Signature of Patient (or Personal Representative) _____ Date _____

Printed Name of Patient (or Personal Representative) _____ Relationship _____

Printed Name of Witness: _____ Employee Job Title _____