ROSEMAN MEDICAL GROUP
ROSEMAN UNIVERSITY OF HEALTH SCIENCES

General Consent for Care and Treatment

Patient Name _____ Date of Birth _____

To the Patient: You have the right, as a patient, to be informed about your condition and any recommended surgical, medical or diagnostic treatment(s) and/or procedure(s) your provider believes you need. to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the potential risks involved. At this point in your care, no specific treatment plan has been recommended.

The purpose of this consent is to obtain your permission to perform reasonable and necessary medical examinations, testing and treatment. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Roseman Medical Group. This consent will remain fully effective until it is revoked in writing.

I agree to provide accurate and complete information about my health history, condition(s) and presenting complaint, to agree upon a treatment plan and follow that plan.

I understand that I have the right to discuss the treatment plan with my provider or members of his or her team to learn more about the purpose, potential risks and benefits of any test, treatment or procedure recommended. I have the right to ask questions.

I agree that I am voluntarily requesting your provider (or his or her designees) to perform reasonable and necessary medical examinations, testing and treatment for the reasons that brought you to this office. You also agree that you understand that 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).

I am aware that Roseman Medical Group is a place where future health care providers are taught and that a learner may be present and participate in your care. My provider will always tell you when a learner is present, and what that learner will be doing. I can refuse, if I wish, to have a learner present.

I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed at Roseman Medical Group.

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

Patient /Legal Guardian Signature_____ Date_____
(If patient is a minor, parent/legal guardian must sign on their behalf)

Relationship to Patient _____