Desert Star Healthcare

Consent for Treatment

Patient Name:_____ Date of birth:_____

As a patient, you have the right to be informed about the state of your health and any recommended medical, diagnostic, or surgical procedure that will be used during your care at this practice so that you may make informed decisions as to whether or not to undergo any recommended treatment.

This consent form gives us your permission to examine you and perform the evaluations necessary to evaluate your health and identify any conditions that may be affecting it. It also gives us your consent to recommend appropriate treatment for any conditions identified during your care and treatment.

By signing this consent, you are giving us your permission to perform reasonable and necessary medical examinations and testing to assess your health and recommend treatment. You authorize this practice, your Nurse Practitioner, and any employee working under the direction of the Nurse Practitioner, to provide medical care to you. This medical care may include services and supplies related to your health and may include but not limited to preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment, or review of physical or mental status/function of the body and the prescribing of drugs, devices, equipment or other items required to diagnose and treat a medical condition.

This consent includes contact and discussion with other health care professionals who may be consulted regarding your care and treatment. You are also indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended.

This consent allows Desert Star Healthcare to file for insurance benefits to pay for the care you receive. You understand that Desert Star Healthcare will have to send your medical record information to your insurance company.

You understand that you must pay your share of the costs not paid by insurance. If you do not have insurance, you understand that you are responsible for all charges incurred during your evaluation and treatment.

You have the right to discuss the purpose, potential risks and benefits of any test ordered for you during your treatment plan with your healthcare provider. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

You also have the right to refuse any treatment recommended by the healthcare provider. If you do refuse a specific treatment, you may be asked to sign an "*Against Medical Advice*" form

documenting your understanding of the risks and benefits of the proposed treatment and the risks of refusal.

You have the right at any time to discontinue services with this clinic.

If additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms specific to the test(s) or procedure(s) to be performed.

The consent will remain fully effective until it is revoked in writing.

_____ _____

Patient's Signature Date