PULMONARY & SLEEP ASSOCIATES OF SOUTH FLORIDA

Teaching Practice Acknowledgment and Consent

Our Commitment to Your Care

At Pulmonary and Sleep Associates of South Florida, we are committed to providing excellent patient care while also contributing to the education and training of future physicians. As a teaching practice affiliated with physician training programs, medical fellows (licensed physicians in advanced specialty training) and other supervised trainees may participate in aspects of your care.

Trainee Participation May Include:

- Reviewing your medical history
- Participating in your office visit or evaluation
- Asking questions related to your health concerns
- Assisting with care coordination
- Discussing your case with the supervising physician
- Participating in procedures or clinical care under supervision

Please Note:

- All fellows are licensed physicians receiving specialized advanced training.
- Your attending physician remains ultimately responsible for your care.
- Trainee participation enhances both patient care and medical education.
- Your privacy is maintained in accordance with HIPAA and applicable law.
- **Procedures:** When a procedure such as bronchoscopy, thoracentesis, or pulmonary function testing is planned, a separate procedure-specific consent will be provided addressing trainee involvement.

Your Right to Choose

Your comfort is important to us. If you prefer not to have a fellow or trainee involved in your care, please let a member of our staff know. While certain educational activities are part of our practice model, we will make every reasonable effort to accommodate your preferences without compromising your care.

Acknowledgment and Consent

By signing below, I acknowledge and agree that:

- ■ I understand that Pulmonary and Sleep Associates of South Florida is a teaching practice.
- ■ Fellows and other appropriately supervised trainees may be involved in my care.
- ■ My attending physician remains ultimately responsible for my treatment.
- ■ Separate consents will be provided for specific procedures where required.
- ■ I have had the opportunity to ask questions regarding trainee involvement.
- ■ I consent to the participation of supervised fellows and trainees in my care.

Patient Full Name _____

Date of Birth _____

Date _____

Patient Signature _____

Authorized Representative (if applicable) _____

Relationship to Patient _____

Completed at new patient intake and retained in the patient's medical record. A copy will be provided to the patient upon request. For questions, please contact our office.