



VERIFICATION OF INFORMED CONSENT

FOR GENERAL CARE AND TREATMENT FOR ADULTS

TO THE PATIENT: This consent form is simply an effort to obtain your permission to perform the consultation or evaluation necessary to identify the appropriate plan, treatment and/or procedure for any identified condition(s) or needs. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. 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 includes consultation and evaluation for obtaining Patient Navigator services for Medicare, Housing, Food Stamps, Social Security, and Outreach.

I, _____, am an adult 18 years of age or if under 18 I am emancipated by virtue of marriage, active duty service in the military, court order or living separately from my parents and managing my own financial affairs, i.e. self-supporting and I voluntarily consent to and authorize Terry Reilly, its staff, physicians, and other practitioners to administer, provide, and perform, such general medical care, tests, routine procedures, and other services that are deemed necessary, advisable, or beneficial by the providers to effectively diagnose and treat me. This includes all routine diagnostic tests and procedures, including x-rays, the administration or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. STI testing and treatment and pregnancy testing may be included in routine diagnostic testing if applicable. I understand that no guarantees have been made to me as to the results or effectiveness of such treatment and care for my condition.

Excluding a medical emergency or extraordinary circumstances, I understand that no substantial procedure will be performed without providing me with an opportunity to give or refuse informed consent for that specific procedure. In giving my general consent for care and treatment, I understand that I retain the right to refuse any particular examination, proposed care, testing, surgery, procedure, treatment, therapy or medication, including HIV testing, and that I have the right to revoke this general consent for care and treatment at any time. My refusal to consent to a recommended procedure will not jeopardize my right to receive appropriate medical care.

I voluntarily request Terry Reilly and its medical, dental, nursing, behavioral health, pharmacy and other professional staff or their designees, including learners, as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care and treatment at Terry Reilly.

HIV testing will be offered as part of the routine laboratory tests recommended. Receipt of Family Planning Services is not a prerequisite to receive any other services offered by Terry Reilly Health Services.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS VERIFICATION OF **INFORMED CONSENT FOR GENERAL CARE AND TREATMENT FOR ADULTS**. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS, AND ANY QUESTIONS THAT I HAD HAVE BEEN ANSWERED BY STAFF TO MY SATISFACTION.

Signature of Patient

Printed Name of Patient

Date

Patient is unable to sign because _____. For this reason, I hereby verify that I have given my consent for general care and treatment on behalf of the above-named patient.

Signature of Legal Representative

Printed Name

Date