330058

Facility:

GENERAL CONSENT FOR TREATMENT

NYC HEALTH+ HOSPITALS

Chart No.

Name

Unit

(Patient Imprint Card)

FORM A

For patients seeking in-patient, out-patient and/or emergency room services.

1. I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine dental and medical care, including vaccination. I understand that these services will be provided to me by physicians, dentists, nurse practitioners, midwives, physician assistants and other health care providers, some of whom may be in training. I have not been given any guarantees as to the results of the services I will receive.

2. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.

3. I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking X-rays, use of local anesthesia and other non-invasive procedures.

_____ _____ **and** _____ **am**
Signature of Patient or Parent/Legal Guardian of Minor Patient **Date** **Time** **pm**

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

_____ _____ **and** _____ **am**
Signature of Health Care Agent/Legal Guardian **Date** **Time** **pm**
(Place a copy of the authorizing document in the medical record)

_____ _____ **and** _____ **am**
Signature and Relation of Surrogate **Date** **Time** **pm**

WITNESS:

I, _____ am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

_____ _____ **and** _____ **am**
Signature and Title of Witness **Date** **Time** **pm**

INTERPRETER/TRANSLATOR: (To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

_____ _____ **and** _____ **am**
Signature of Interpreter/Translator **Date** **Time** **pm**