DMC PRIMARY CARE
Derry Medical Center

GENERAL CONSENT FOR TREATMENT

Patient Name (First and Last) _____ Date of Birth_____

You have the right, as a patient/parent/guardian, to be informed about any condition or the recommended diagnostic testing or procedures 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.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

I understand that I have the right to refuse to consent to any proposed care, testing, treatment, surgery or procedure.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at DMC Primary Care, Derry Medical Center, or any other satellite office under common ownership.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, or Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at DMC.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

CONSENT TO RELEASE INFORMATION

I understand that protected health information (PHI) may refer to medical or health information, including prognosis, psychological or mental illness, prescription, laboratory and other medical results, including HIV tests or diagnoses. PHI typically includes information about my symptoms and health condition; results of physical examinations and diagnostic tests; a plan regarding future care and treatment; as well as demographic and photographic identifiers.

Such individually identifiable information about me will be used, shared, or disclosed only for the purpose of treatment, payment, and healthcare operations, or as required by law.

Otherwise, my PHI will not be inspected or released without my specific authorization except in certain circumstances, which are outlined in DMC's Notice of Privacy Practices. I understand that the DMC Notice of Privacy Practices is publicly posted in a clear and prominent location in all DMC facilities and is available on the DMC website. The Notice of Privacy Practices outlines how my PHI may be used and disclosed. The Notice of Privacy Practices also details my rights to access, limit, obtain, and correct my medical and health care information, and my right to make a complaint if I feel my privacy rights have been violated. I understand that I may request a written copy of the Notice of Privacy Practices at any time and DMC staff will provide it to me.

Additionally, I am aware that data and information concerning essential medical treatment and healthcare services rendered on my behalf may be disclosed, when necessary, to healthcare providers in emergent situations and/or to public and private health insurance plans in order to receive payment as outlined in DMC's Financial Policy. I acknowledge that I am required to sign the DMC's Financial Policy in order to receive care or treatment from DMC Primary Care.

I hereby authorize DMC Primary Care to use my medical information for their exercise of rights, title and interest in the payment from healthcare insurance services or third-party payers, including but not limited to, Medicare, insurance, among others for which are only covered by them.

PHOTOGRAPHIC CONSENT

I hereby give my consent to the taking of photographs or images for the purpose of identification for treatment if necessary, or for the purpose of identity for records and/or payment purposes. These photographs shall be kept by the medial facility for the incidental purpose as it may be deemed necessary for the processing of my information.

Signature (Patient or Parent or Guardian): _____ Date: _____

Print name (Parent or Guardian) _____

For office use:
Witness printed name: _____ Signature: _____ Date: _____