CONSENT TO TREAT (INFORMED CONSENT)

Date of Service: _____ Clinician: _____

Patient's Name: _____ Date of birth: _____

To the Patient: Please read this document in its entirety and discuss with your provider before completing. **Informed consent** is an important process of communication between you, the patient and the health care provider. As a patient of OneCare Health- Advanced Practice Health & Wellness, Corp, you have the right to be informed about your conditions and diagnosis (s), and about the treatment plan recommended for you as well as the benefits and potential risks of these treatments, procedures and/or alternative treatments options, including the option of receiving no treatment at all. You have the right to have all comments, questions or concerns addressed and fully explained to you. It is our obligation to provide you with the necessary information you need in order for you to make an informed decision about whether or not you choose to receive medical treatment at our facility.

THIS SECTION TO BE PRINTED BY THE HEALTH CARE PROFESSIOANL

Patient Presenting Complaint(s): _____

_____

Pertinent Examination Findings:

_____

_____

_____

Working Diagnosis: _____

Management Plan:

- RX
- Tx Regimen (Specify): _____ (I.E. PT, CHIRO, CHEMO)
- Referral/Consultation (Specify): _____
- Patient Education/Lifestyle Modification Recommendations. Recommendations/Suggestions
- Other (Specify): _____

Prognosis:

_____

_____

THIS SECTION TO BE COMPLETED BY THE PATIENT

I hereby consent to treatment by OneCare Health- Advanced Practice Health & Wellness, Corp.
I authorize the medical team, including the nursing staff as well as any students or residents to provide medical care including telehealth services and to administer diagnostic, radiological and or therapeutic procedures and treatments as the medical team determines is necessary or advisable in my care or for the care of an obstetrical patient or a pediatric patient. If I am singing this document on behalf of another person, I acknowledge that I am consigning on behalf of said patient and I will indicate the relationship (parent, relative, health care agent, guardian, surrogate) where indicated below. I authorize release of certain information including but not limited to immunization records to a state and/or federal registries. If at any time a member of the health care team involved in your care becomes exposed to hazardous bodily fluids that could result in the transmission of a bloodborne disease, such as Herpes, Hepatitis, HIV or Syphilis as well as other potential bloodborne disease, a blood sample will be obtained from you, the patient and tested for said diseases in an effort to rule out any exposure to the health care member.
I acknowledge that this form authorizes release of my HIV, Hepatitis and other potential bloodborne communicable disease results to the healthcare worker who was exposed and their healthcare provider for purposes of providing post-exposure care. I understand that these individuals are prohibited by law from re-disclosing my testing results in a way that could reveal my identity.

I acknowledge that this form authorizes my healthcare team to discuss information related to my post discharge support and care with individual named as my caregiver.

I understand that if I have provided Emergency Contact names that OneCare Health- Advanced Practice Health & Wellness, Corp considers these individuals as my "designated representative(s)." This facility may share my protected health information with my designated representative to the extent permitted by law and to the extent that I have directed otherwise.

Electronic medical records: I authorize OneCare Health- Advanced Practice Health & Wellness, Corp to retrieve my health records and any medications I am currently talking through EMR/HER software and e-prescribing system and allow them to be imported into my electronic medical record here at OneCare Health- Advanced Practice Health & Wellness, Corp.

I allow OneCare Health- Advanced Practice Health & Wellness, Corp to provide me with medical treatment.

I allow OneCare Health- Advanced Practice Health & Wellness, Corp to file any insurance claims / benefits to collect compensation for the care that was rendered to me on the day of my visit
. I understand that:

- OneCare Health- Advanced Practice Health & Wellness, Corp will need to communicate details of my visit today to my insurance company.
- I must pay for any of the treatment received today that is not covered by my insurance company.
- I do not have insurance coverage and agree to pay the balance in full for todays visit.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.
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I acknowledge that all diagnosis (s), treatments and therapeutic interventions that were recommended to me were clearly explained including the purpose of each of them. The "risks & benefits" as well as "alternative to treatments" have also been clearly explained to the best of my knowledge. I have been given the opportunity to discuss these treatment options and have all my questions and concerns, if any addressed by the health care provider/team.

At this time:

( ) I have no questions in regards to the recommended treatment plan. All information has been communicated to me in a clear and concise manner and it meets my satisfaction.

( ) I have the following questions or concerns and/or would like to receive the following additional information about my recommend treatment (please print):

_____

_____

_____

I understand that the practice of medicine, chiropractic care and any other health services / profession is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of my treatment. I have made my decision regarding the treatment that I wish to receive freely and voluntarily and waive my right to seek legal action / council, bring upon claims for any of what I have signed above. By signing below, I hereby give my permission and consent OneCare Health-Advanced Practice Health & Wellness, Corp and all of its affiliates and contractors to receive treatment.

I am 18yrs of age or my parent, guardian, or a agent is singing on my behalf. I am cognizant, lucid and oriented. Fluent and proficient in understanding the English language and if not, assistance was/is provided/offered to me by an interpreter/translator _____(print name)

_____	_____	_____
Signature	**Print Name**	**Date**
Patient/Relative/Agent/Guardian	**Relationship, if other than patient**	