Methodist ORTHOPAEDIC SURGICAL ASSOCIATES

Methodist MEDICAL GROUP

General Patient Consent for Care

General Consent to Care:
I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Methodist Medical Group (MMG)/Methodist Orthopaedic Surgical Associates (MOSA) on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Methodist Orthopaedic Surgical Associates (MOSA) is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine
is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Methodist Orthopaedic Surgical Associates (MOSA).

Telemedicine
I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

To the Patient:
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.

Signed Consent

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 this office 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.

I hereby give my consent to treat minor child/children below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Methodist Medical Group (MMG)/ Methodist Orthopaedic Surgical Associates (MOSA). Any care deemed medically necessary may be provided with **or** without my presence:

Child: _____ Date of birth _____

Child: _____ Date of birth _____

Child: _____ Date of birth _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ [ ] *Patient under 18 years of age* _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Printed Name of Patient or Legal Guardian **Relationship to Patient**

This consent to medical treatment will expire 12 months from the date signed, or until revoked in writing