Milner Vein & Vascular

PATIENT CONSENT FORM

CONSENT FOR ROUTINE PROCEDURES & TREATMENTS

We are required by law to obtain a consent to treat and disclose "all material risks and alternative treatments." I understand that it is not possible to list every material for every Procedure or Treatment and that this form only attempts to identify the most common material risks and the alternatives associated with the Procedure or Treatments.

The Procedures may include, but are not limited to the following:

(1) **Needle Sticks**, such as injections (shots), intravenous lines, or intravenous injections. The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis of limb or death. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

(2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternative sexist.

(3) **Administrations of Medications** whether orally, rectally, topically or through the eye, ear, or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

By signing this form:

- I consent to Healthcare Professionals performing Procedures as they deem reasonably necessary in the exercise of their professional judgement, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained; and
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.
- **If I have any questions or concerns regarding these Treatments or Procedures, I will ask my physician to provide me with additional information.**
- In order to insure medication safety and lack of drug interactions, I grant DeKalb Medical and its staff the right to access my electronic pharmacy and prescription information.

Signature of Patient (or authorized person to sign): ____

Printed Name of Patient: ____

Reason Patient Unable to Sign (if applicable): ____

Date Signed: __________________________

Acknowledgement of Receipt of Notices of Privacy Practices (HIPAA): I acknowledge that I have received the notice of Privacy Practices.

____ ________________________________

Signature Date

Patient Approval From for Physician Assistant: If this practice has a certified Mid-Level Provider available to treat patients for the level of care, which have been approved by the Georgia State Board of Medical Examiners, your signature on this form conveys that you are in agreement with being treated by a Mid-Level Provider, who is acting under the direct supervision fo a physician.

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Patient Signature

HIPAA stands for the Health Insurance Portability and Accountability Act. This federal law has brought many changes to the healthcare industry, specifically in areas such as:

- Protecting and ensuring the privacy of patient's health information
- Regulation to protect electronic health information
- Standards for transmitting electronic data

As your provider, we are committed to maintaining the privacy of your healthcare information, as well as communicating with you in the most effective manner. Please take a moment to complete this form to ensure that we can contact you.

I authorize the DeKalb Medical Physicians Group to contact me regarding my medical information by means of the listed methods. I will also be responsible for contacting this office should this information change.

Home telephone #: ________________________________
May we leave messages on your home answering machine? Yes No

Work telephone #: ________________________________
May we leave messages on your work voice mail? Yes No

Cell phone #: ________________________________
May we leave messages on your cell phone voice mail? Yes No

The providers/staff may use or disclose the following health information only to the following list of people:

- All test results Yes No
- The entire medical record Yes No
- Today's chart note Yes No
- Any healthcare provider or facility Yes No
- Spouse: Yes No Name: ________________________________
- Parent(s): Yes No Name: ________________________________
- Children: Yes No Name: ________________________________
- Other: Please give name and relationship (aunt, uncle, cousin, parent, etc.)

Name: ____

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Patient/parent/guardian signature: ________________________________

Date signed: ______________________