Fetter Health Care
NETWORK

51 Nassau Street
Charleston, SC 29403
Phone (843) 722-4112
Fax (866) 285-7156

General Consent for Care and Treatment Consent

I, _____, or the Parent or Legal Guardian(s) of: _____, a registering patient of Fetter Health Care Network, hereby give my consent to be provided medical treatment as necessary.

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure 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. At this point in your care, no specific treatment plan has been recommended. 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. 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.

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.

You voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), 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 you to seek care at this practice. You 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).

You further understand that medical information may be shared on an as needed basis with other referred medical sources and that any medically necessary procedure may be performed if it is in the best interest of the health of the patient as deemed necessary by the medical staff of Fetter Health Care Network.

AUTHORIZATION AND CONSENT

I certify that I have read and fully understand the above statements and consent fully and voluntarily to the contents of those statements. I further provide my authorization for the performance of the evaluation, treatment and procedures described in the statements.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative