



GENERAL CONSENT TO CARE AND TREATMENT AGREEMENT

TO THE PATIENT/GUARDIAN:

I have the right to be informed about my condition and the recommended diagnostic or therapeutic procedures to be used so that I may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

I consent to allow the providers of the Healthy Sleep MD to perform necessary medical examinations and tests to diagnose and treat my health conditions.

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

By signing below, I am indicating that I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended.

I 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.

I have the right at any time to discontinue services. I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me.

If I have any concerns regarding any test or treatment recommend by my health care provider, I am encouraged to ask questions.

I voluntarily request any health care provider at Healthy Sleep MD as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

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 understand that Healthy Sleep MD is not responsible if I decline or do not complete their recommended testing or treatment for my condition(s).

I understand healthcare students and trainees may be involved in my care.

I have the right to have a chaperone present when I am with my provider. A chaperone is required for any sensitive examination unless I decline a chaperone in writing. If I am consenting on behalf of a child under 11 years of age, I may serve as the chaperone.

I understand that Healthy Sleep MD is not responsible for any of my clothing, valuables, or other personal belongings left behind. I understand that I hereby release Healthy Sleep MD from any liability for any and all personal possessions which I choose to keep with me during my office visit or any sleep studies.

RELEASE OF INFORMATION I hereby authorize Healthy Sleep MD, or its designee, to release information, in written form, by phone, or facsimile machine, contained in the patient's medical records. I specifically authorize the release of drug and alcohol abuse records in accordance with the Federal Regulations and/or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases.

I hereby assign, transfer, and set over unto Healthy Sleep MD as its interest may appear all benefits now due or becoming due to me by virtue of the present office treatment.

AGREEMENT TO PAY FOR SERVICES I understand that I am liable and responsible for any health insurance deductibles and coinsurance portions of my bill. I also understand that I am responsible to pay for all services to be rendered to the patient whether signing as agent or as patient.

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

Signature of patient or representative

Date

Printed name of patient or representative

Relationship to patient

Signature of witness

Date

Name of witness

Employee job title