



GENERAL CONSENT FOR TREATMENT

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 decide whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. No specific treatment plan has been recommended at this point in your care. 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 Plattsburgh Otolaryngology–Head and Neck Surgery, PLLC, (Plattsburgh ENT) with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you indicate that (1) you intend this consent to continue 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 tests or treatment your healthcare provider recommends, we encourage you to ask questions.

I voluntarily consent the physician and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and medical 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 before the test(s) or procedure(s).

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

Signature of Patient or Patient Representative

Date

Printed Name of Patient or Patient Representative

Relationship to Patient

Printed Name of Witness

Signature of Witness