GENERAL CONSENT FOR TESTS, TREATMENT, PHOTO, VIDEO AND SERVICES.

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services of treatments rendered by my physician, consulting physicians, fellows, residents, interns, and their associates and assistants, or rendered by facility personnel under the instructions, orders of direction of such physician(s), fellow(s), resident(s), or intern(s).

I agree and understand that all physicians (including fellows, residents, and interns) dentists, oral surgeons, and podiatrists involved in my care in any way are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for the acts or omissions of the aforementioned. Service may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science; and further understand that no guarantee has been or can be made as to the results of the treatments, care or examination in the Facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be preformed by such physician and/or one or more additional physician, fellows, residents, interns, and employees of the Facility. I understand that one or more physicians, fellows, residents, and/or interns at the Facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physician and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

I consent to the photography or videotaping, including appropriate portions or my body, for medical and medical records documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

The under signed certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative Date Time

Relationship to Patient Interpreter, if utilized

Witness Signature If telephone consent, 2nd witness signature