Dekalb Family Practice & Geriatrics

4961 Buford Highway ▪ Suite #100 ▪ Chamblee, GA 30341
Phone: **(770) 458-8497** Fax: **(770) 220-2839** **www.dekalbfamilymed.com**

Consent to Routine Procedures & Treatments

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment technologists, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals"). While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.
The Procedures may include, but are not limited to the following:
1) Needle Sticks, such as shots, injections, intravenous lines, or intravenous injections. The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration, disfiguring scar, loss of limb function, paralysis or death. Alternatives to Needle Sticks include oral, rectal, nasal, or topical medications that may be less effective.
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, musculoskeletal or internal injuries, nerve damage, paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures, no practical alternatives exist.
3) Administration of Medications via appropriate route whether orally, rectally, topically or through my eyes, ears or nostrils, etc. 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, 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, no practical alternatives exist.
5) Insertion of Internal Tubes such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating. Apart from external collection devices, no practical alternatives exist.

Personal Property and Valuables: The office shall not be liable for the loss or damage of any personal belongings, including but not limited to money, jewelry, hearing aids, or dentures.

I understand that:

- The practice of medicine is not an exact science and that no Guarantees or Assurances have been made to me concerning the outcome and/or result of any Procedures;
- The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; and
- Some of the health care professionals performing services in this office are independent contractors who are responsible from their own actions and the office shall not be liable for the acts or omissions of any such independent contractors.

By signing this form:

- I consent to Healthcare Professionals performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, 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 Procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional Informed Consent documents.

_____	_____	_____	_____
Signature of Patient (or Person giving consent)	Relationship	Date	Time
_____	_____	_____	_____
Patient unable to sign because	Witness	Date	Time

Dekalb Family Practice & Geriatrics

4961 Buford Highway • Suite #100 • Chamblee, GA 30341

Phone: (770) 458-8497 Fax: (770) 220-2839 www.dekalbfamilymed.com

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I hereby acknowledge that I have received a copy of the Dekalb Family Practice & Geriatrics, LLC "Notice of Privacy Practices."

_____	_____	_____
Print Name of Patient	Date	Time
_____	_____	_____
Signature of Patient or Patient's Authorized Representative	Date	Time

As the Patient's Authorized Representative, my relationship with the patient is _____

The Patient is unable to sign because _____

ASSIGNMENT OF BENEFITS- FINANCIAL AGREEMENT

I authorize the release of any medical information to any insurance company, Medicare, Champus, Managed Care Insurance, third party administrator, or other payer that is necessary to process the claim and request payment of benefits either to myself or to Dekalb Family Practice & Geriatrics, LLC.
I understand that I am financially responsible for all charges, whether or not covered by insurance. Also, if my account has to be turned over to collections, I agree to pay all costs of collections including attorney fees.
I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

_____	_____	_____
Signature of Patient or Patient's Authorized Representative	Date	Time

AUTHORIZATION TO RELEASE INFORMATION

DeKalb Family Practice & Geriatrics, LLC (DFPG) is authorized to release information contained in my medical record, before, during or after date of service, via copy, telephone or fax:

- To my insurance company(s), their agents or other third party payor and/or government or social service agencies, which may pay for any part of the medical expenses incurred or authorized by representatives of DFPG.
- As mandated by law.
- To alternate care providers, including community agencies and services, as ordered by my physician or as requested by me or my family for post-hospital care or out-patient services.

This information authorized to be released shall include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment, information about drug and/or alcohol abuse or treatment of same and/or psychiatric or psychological information. The recipients are prohibited from any re-disclosure of this information.

I waive any privilege pertaining to such confidential information. DFPG, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. I acknowledge that this consent is valid until such time as all bills related to medical care have been paid and/or post-care arrangements have been made. I further understand that I can withdraw this consent for release of information at any time prior to expiration. The revocation shall not pertain to information previously released.

Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

I acknowledge that I have read and understand this form and explanation of my responsibilities for services I receive from DFPG providers:

_____	_____	_____	_____
Signature of Patient or Authorized Representative	Patient Name	Date	Time