Center for NEUROSCIENCES

CONDITIONS OF TREATMENT & GENERAL CONSENT FOR TREATMENT

_____ [←*Pt Initial*] **GENERAL CONSENT FOR TREATMENT AND HEALTH CARE SERVICES**

I consent to receive treatment and health care services from Center for Neurosciences (CNS) and CNS physicians, nurse practitioners, physicians' assistants, fellows and other health care providers who work at CNS. I understand that some health care providers might not be employees or agents of CNS and CNS is not liable for their actions or omissions. CNS participates in residency training and other training programs for health care personnel. I consent to the involvement, in my care and treatment, by resident physicians and other trainees. I understand residents and trainees will be supervised by appropriate CNS personnel. I understand that some trainees might also observe for training purposes.

I consent to all health care services, including without limitation, routine outpatient and clinic services, laboratory tests and procedures, injections, diagnostic testing, procedures, medications, telemedicine visits, and consultative services.

_____ *[←Pt Initial]* **CONSENT FOR USE AND RELEASE OF INFORMATION**

I acknowledge and understand that, by law, the Center for Neurosciences (including, without limitation, its treating and referring providers and staff) may disclose/release, , my medical and/or financial records, without my consent, for: (1) treatment purposes(for example, to health care providers or facilities that need the information for my continued care, etc.); (2) purposes related to payment for services (for example, to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment, etc.); or, (3) health care operations of the Center for Neurosciences (for example, quality assurance, accreditation, utilization review, etc.). For more detailed information about the way my information may be used or released, I can read the CNS Notice of Privacy Practices.

Patient Name Print: _____DOB: _____

Patient Signature: _____Date: _____

_____ Date: _____

Authorized Representative/Legal Guardian Signature (if Patient does not sign)

_____

Authorized Representative/Legal Guardian Name