PATIENT CONSENT FOR TREATMENT

Consent for treatment: I hear by voluntarily consent to care, treatment, testing and all other services performed by Center for arthritis and osteoporosis PC. At the same time, I do understand that I have the right to refuse consent to any proposed care, treatment, testing, surgery, or procedure. Moreover, I have the right to ask questions and discuss my concerns with my healthcare provider.

I am aware that the practice of medicine and surgery is not an exact science. I understand that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees have been made to me as to the outcome of my care, examination and/or treatment at Center for Arthritis and Osteoporosis PC.

While I understand that I am required to sign this consent annually or as necessary, I may revoke this consent at any time by writing to the Center for Arthritis and osteoporosis P.C. health information services (HIS), 3100 Princeton Pike, suite D, building 4, Lawrenceville, NJ 08648. **_________(Initial)**

Release of medical information: I understand that Center for Arthritis and Osteoporosis PC shall maintain both electronic and paper-based documentation of the medical care received. This medical record will typically include individually identifiable information about my symptoms and health condition; results of physical examination or a diagnostic test; a plan regarding future care and treatment; as well as demographic and photographic identifiers. Such information about me is protected health information (PHI) and, as such, will be used, shared or disclosed only for the purpose of treatment, payment, and healthcare operations. Otherwise, it will not be inspected or released without my specific authorization except in certain circumstances outlined in the **Notice of Privacy Practices**.

________(Initial)

Additionally, I'm aware that the data and information concerning essential medical treatment and healthcare services rendered on my behalf may be released, when necessary, to healthcare providers in emergent situation and/or to public and private health insurance plans in order to receive payment as outlined in the Center for Arthritis and Osteoporosis PC financial policy. However, I may request that PHI associated with that portion of my healthcare, at Center for Arthritis and Osteoporosis PC, for which I paid out-of-pocket, not be disclosed to my health plan or insurance company. I understand this request must be in writing.

A copy of the **Notice of Privacy Practices** is posted in both English and Spanish within the facility, and paper copies available at the registration desk. **_____(Initial)**

Patients rights and responsibilities: I acknowledge that my healthcare is a partnership between Center for Arthritis and Osteoporosis PC and me; hence, I agree to actively participate and accept both my role and responsibility in reference to my healthcare and the rights available to me. A list of patient rights and responsibilities posted in both Spanish and English with the facility. A copy of this this is available

upon request. ____**(Initial)**

Advance directives: Adults 18 and older have the right either (a) to give directions about their future medical care or (b) to designate patient representatives to make medical decisions for them if they lose individual decision-making capacity. I understand the information about advanced directives is available to me upon request.

______**(Initial)**

Patient Name: ____ Date:________

(sign)

Patient Representative: ____ Date:_________

(print & sign)

Clinical Representative Initials: ____ Date:_________