Boone's Creek Medical

Printed Patient Name_____

Consent for Treatment

1. **General Consent for Treatment and Test**: I consent to treatment by the Boone's Creek Medical physician, nurse practitioner, nurses and staff for my illness and/or health evaluations, including but not limited to x-rays, blood tests, laboratory procedures, medications and minor procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my medical care. I understand that State law requires physicians to report certain communicable diseases to the Health Department.

2. **Independently Practicing Doctors**: I understand and agree that most of the radiologists, pathologists, anesthesiologists and some allied health professionals are engaged in the practice of their professions on behalf of themselves or other corporations and do not practice as employees of Boone's Creek Medical. I hereby authorize payment directly to the physicians. I also authorize the release of my medical information necessary to process these insurance claims.

3. **Release from Liability for leaving Against Medical Advice**: I agree that if I leave a physician's office against the advice of my physician or the Boone's Creek Medical staff, then Boone's Creek Medical, its personnel, and my physician are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice.

4. **Authorization to Release Medical Information**: I authorize Boone's Creek Medical and all physicians involved in my care to disclose and release my medical information (which may include alcohol and drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to each other and to any person or organization which is or may be liable or responsible for payment of my bill, including Medicare intermediaries and fiscal agents.

5. **Controlled Substance Policy**: It is not the policy of Boones Creek Medical to write controlled substances for our patients. Patients who require chronic pain and mental health medications will be directed to a specialist for evaluation and treatment.

6. **Students**: We often have students working with us. If you do not wish for a student to be in the room, you can let the nurse or provider know.

I have read and understand this document, and agree to its terms.

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Patient/Authorized Party	Relationship	Date	Witness