



Consent for Treatment

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

1. Purpose of Consent

I, the undersigned, voluntarily consent to receive medical care and treatment provided by the physicians, advanced practice providers (APPs), and other medical support staff at The Vein Center of Cincinnati (hereafter referred to as 'the Practice'). I understand that by signing this consent, I am authorizing the Practice to provide healthcare services to me, which may include, but are not limited to:

- Medical examinations
- Diagnostic procedures, including laboratory tests and imaging studies
- Medical and surgical treatments, including minor surgical procedures
- Administration of medications
- Therapeutic interventions
- Preventative care services
- Referrals to other healthcare providers or facilities for specialized care

2. Scope of Consent

I understand that:

- The physicians, APPs, and medical support staff involved in my care are licensed and qualified to provide the necessary healthcare services.
- I may receive care from physicians, physician assistants, nurse practitioners, registered nurses, medical assistants, and other healthcare professionals as deemed necessary for my care.
- Healthcare providers may discuss my case and share relevant medical information with each other to ensure continuity and quality of care.
- The Practice may use telemedicine services when appropriate to facilitate my care.

3. Risks and Benefits

I acknowledge that all medical procedures, including diagnostic tests and treatments, carry certain risks, including but not limited to adverse reactions to medications, complications, and the possibility of unsuccessful outcomes. The potential benefits, risks, and alternatives of proposed treatments will be explained to me before proceeding.

4. Right to Refuse Treatment

I understand that I have the right to refuse any recommended medical treatment or procedure. I also acknowledge that I am responsible for the consequences of refusing treatment, including potential adverse health outcomes.

5. Confidentiality and Privacy

I understand that my medical information will be kept confidential and will only be disclosed in accordance with federal and state laws governing the privacy of health information (HIPAA). I have the right to access my medical records and to request amendments to them if necessary.

6. Financial Responsibility

I agree to be financially responsible for the costs associated with the care and treatment provided by the Practice. I understand that I am responsible for any charges not covered by my insurance plan, including co-pays, deductibles, and non-covered services.

7. Emergency Situations

In the event of a medical emergency, I consent to the Practice providing necessary care, including life-saving measures, until I can be transferred to an appropriate facility or further treatment can be provided.

8. Duration of Consent

This consent remains valid for the duration of my care at the Practice unless revoked by me in writing. I understand that I have the right to revoke this consent at any time, except to the extent that the Practice has already taken action based on this consent.

9. Acknowledgment and Understanding

I acknowledge that:

- I have had the opportunity to ask questions about this consent form and the proposed treatment, and all my questions have been answered to my satisfaction.
- I understand the information provided to me and voluntarily consent to receive care and treatment at the Practice.

Patient Signature: _____ Date: _____

Legal Guardian/Representative (if applicable): _____

Relationship to Patient: _____ Date: _____

Witness (Practice Representative): _____ Date: _____