NH2917

NORTHSIDE HOSPITAL

**English** - Spanish

ADDRESSOGRAPH

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Name of Medical Practice

Patient Name: _____ Date of Birth: _____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

**Consent To Routine Procedures.** I consent to medical care and procedures while I am a patient at a Northside Hospital affiliated medical practice ("Practice"). This includes routine testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other advanced practitioners. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags, including procedures that may be unforeseen or not known to be needed at the time this consent was obtained ("Minor Procedures").

The Routine Procedures may be performed by physicians, nurses, technicians, nurse practitioners, physician assistants or other healthcare professionals. The Minor Procedures are performed by a physician, physician assistants, or nurse practitioners. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

**Consent To Download Prescription Records.** The Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will cross through and initial this paragraph. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

**Testing For Blood-Borne Pathogens.** Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. If I want to refuse HIV or syphilis testing, I will cross out and initial this sentence. (3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time.

**Oncology Social Workers.** The Practice may employ or contract with a Licensed Clinical Social Worker (LCSW) or similar qualified staff to assess and communicate patient needs to other providers and to provide referrals to support services. The LCSW's records are not psychotherapy notes and are not subject to the patient therapist privilege.

**Students.** The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will cross through and initial this paragraph.

**Medications From Outside Source.** I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to the Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

**TELEHEALTH:** I consent to telehealth consultations recommended by my physician. During the consultation, my medical history and test results may be discussed with licensed health professionals through telecommunication technology. In some cases, a physical exam will be performed. Unless I object, a non-medical technician may be present to assist with the technology and audio or video recordings may be taken. I can withhold or withdraw consent to the telehealth consultation at any time without affecting my right to future care, or risking the loss of any Medicaid or other benefits to which I may be entitled. If I do not consent to a telehealth consultation, some services may not be available at all Northside locations. I have been informed of available alternative options, which may include in-person services. All state and federal laws, including privacy and confidentiality, apply to records of the telehealth consultation. The consulting physician will inform me of any other risks or benefits of the telehealth consultation. I have the right to see appropriately trained staff in-person immediately after the telehealth consultation if an urgent need arises. **If I do NOT consent to telehealth consultations, I will cross out and initial this paragraph.**

Some or all of the health care professionals performing services in this facility are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice;

The healthcare professionals participating in my care will rely on my medical history and 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;

I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and if a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS. I have been informed about and offered a copy of Northside's statement of patient rights and responsibilities.

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

| Witness | Date | Time AM/PM | Signature of Patient or Legal Representative | Date | Time AM/PM |
|---|---|---|---|---|---|

Relationship to patient if not the patient _____

| Interpreter Signature | Date | Time AM/PM | |
|---|---|---|---|
| **Note:** If phone interpretation used, record interpreter ID# | | | Reason Patient unable to sign |



**OUTPATIENT ONCOLOGY GENERAL CONSENT**