NP WALK-IN CLINIC
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GENERAL CONSENT/ PERMISSON FOR TREATMENT

I authorize the performance upon _____ of such
(Name of Patient)
appropriately indicated physical examinations, x-rays, laboratory and other routine diagnostic procedures and treatments as my/the patient's provider considers to be necessary or appropriate for the purpose of diagnosis of my/the patient's condition. I understand the nature of and the need of each procedure and treatment will be explained to me beforehand, and that I am free to refuse anyone or all procedures or treatments if I so choose.

I consent to the diagnostic study and/or disposal by NP Walk-In Clinic authorities of any blood, urine, or other body fluids, stool specimens, or tissues which are obtained in accordance with routine primary care practice and governmental regulation. I further consent to the examination, study and retention of such specimens, and the use of the findings for medical, scientific, or educational purposes provided that the confidentiality of my identity is maintained.

I consent to the present and future prescription and/or administration of medicines or drugs listed in the U.S. Pharmacopeia as may be deemed necessary by my/the patient's provider in the course of my/the patient's diagnosis and treatment with the understanding that the nature of and the need for such medicines or drugs will be explained to me beforehand, and that I shall always be free to refuse each and all of them if I so choose.

I understand that the explanation which will be given to me of the nature, intended purpose, and the reasonable foreseeable risks, consequences, complications, benefits and alternatives of the examination(s), procedure(s) or treatment(s) which may be performed or used in the course of diagnosing or treating my/the patient's condition will not be exhaustive and that other risks and complications may arise but the likelihood of their occurring is not reasonably foreseeable. I have been advised that if I desire a more detailed explanation prior to my consent such explanation will be given to me.

I acknowledge that I have received no warranties or assurances with respect to any benefits which are hoped to be realized, or consequences which may result, from any of the examination(s), procedure(s) or treatment(s) which may be performed or used. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury and even death.

I acknowledge that I have read this document in its entirety and that I fully understand it prior to my signing. I understand that I am to make any inquiries regarding any aspect of my/the patient's diagnosis or treatment which I do not understand. I represent to my/the patient's provider and NP Walk-In Clinic that I am eligible to give this consent.

Signature of Patient or Legal Guardian _____
Date_____

Signature of Provider_____
Date_____