MY HOME TELEMED LLC
Consent to Treatment

TO THE PATIENT: Welcome to our practice. At this point in your care, no specific treatment plan has been recommended, until we have the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified, and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing , and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made, and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions, or to discontinue or decline services.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment by your healthcare provider, we encourage you to ask questions.

I voluntarily request my provider as deemed necessary to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or Representative Date

Printed Name of Patient or Representative Relationship
