Internal Medicine Specialists, P.C.

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

Important: Do not sign this form without reading and understanding its contents.

I hereby apply for and consent to treatment by this Practice and its Medical Staff, and authorize all routine Practice activities, treatments, examinations and diagnostic services. During the course of my care and treatment, I understand that various types of tests, and diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants, or other healthcare professionals ("Healthcare Professionals"). While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

(1) **Needle Sticks,** such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective) or refusal of treatment.

(2) **Physical tests, assessments, and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition, and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) **Administration of Medications** whether orally, rectally, topically, by injection, or through the eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

(5) **Insertion of Internal Tubes** such as bladder catheterizations and enemas, or ear lavages. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal, and possible perforation of the eardrum during ear lavage. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

Consent for Treatment

I (We), the undersigned, have read and fully understand the Consent for Treatment above. My signature acknowledges that I have been given the opportunity to satisfy myself by asking questions about the Consent for Treatment. I voluntarily give my consent to medical office for Practice care. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this medical practice. This consent will remain valid indefinitely, unless revoked in writing by me and delivered to the Office Manager of the practice.

Signed: _____ _____

Patient/Patient's Representative Date

_____ _____ _____

Relationship if Other than Self Witness Date