GYNECOLOGIC ONCOLOGY
OF MIDDLE TENNESSEE

General Consent for Care and Treatment

TO THE PATIENT: You have the right as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

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

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees 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. 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 Personal Representative **Date**

____ __________________________

Printed Name of Patient or Personal Representative **Relationship to Patient**

NO SHOW AND LATE POLICY

These policies assure that patients have access to care when needed by maximizing the utilization of available appointments. They are also used to provide a mechanism for appropriately managing the patient that fails to utilize assigned appointment times without sufficient notice.

NO SHOW POLICY - If a patient is unable to keep their appointment, they are required to cancel their appointment within 24 hours of their scheduled appointment. Barring any unusual circumstance, if you have more than two **(2)** no shows with in a twelve **(12)** month period, you may be dismissed from the practice for failure to follow a physician's recommendation.
Thank you for understanding our No Show Policy. Please let us know if you have any questions or concerns.

LATE POLICY - Barring any unusual circumstance, if a patient is greater than 15 minutes late for their appointment, they will be asked to reschedule. Late patients will be handled on a case by case basis. Thank you for understanding our Late Policy. Please let us know if you have any questions or concerns.

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

____ ___/___/_____

Signature of Patient or Personal Representative **Date**

____ __________________________

Printed Name of Patient or Personal Representative **Relationship to Patient**