Colorectal Health Northwest

General Consent for Care and Treatment

TO THE Patient: You have the right to be informed about your condition and the surgical, medical, or diagnostic procedures suggested for treatment. This includes understanding the risks involved so you can decide whether or not to proceed with any recommended treatment.

Currently, no specific treatment plan has been proposed for you. This consent form is just to ask for your permission to conduct the necessary evaluation to identify the best treatment or procedure for any conditions we find.

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 questions.

I voluntarily request a physician and/or 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).

Oregon law (ORS 441.098) requires us to inform you that:

- You have a choice of where to go when you are referred for a diagnostic test, health care treatment or service.
- When a referral is made, you have to right to talk about your options of where you may go, and the right to choose where you would like to have a test, treatment or service done.
- Your referral will not be denied, limited or withdrawn if you choose another

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**