Consent to Care and Treatment

Medical Treatment: I, the undersigned, hereby consent to and permit my attending physician and his/her designees, CORE Injury Management, PLLC and its employees, and all other persons caring for me to provide me treatment and care as may be deemed necessary and available to me during my stay in the clinic, including but not limited to tests, examinations, anesthetics, x-rays and medical and surgical treatments, and other necessary procedures. I understand that by signing this Consent, I am authorizing them to treat me for as long as I seek care from CORE Injury Management, PLLC or until I withdraw my consent in writing.

I understand that my care is under the control of my attending physicians who may not be employees or agents of CORE Injury Management, PLLC, but rather, independent physicians, and that CORE Injury Management, PLLC is not liable for their acts or omissions of any acts or omissions from following their instructions. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me as the result of treatment or examination at CORE Injury Management, PLLC.

In the event a healthcare worker is expose to my blood or bodily fluid in a manner that pose a risk for transmission of a blood-borne infection during this office visit or outpatient procedure, I am giving my consent to be tested for HIV, at no cost to me, so the healthcare worker can be treated promptly. I authorize release of this information to the exposed healthcare worker and his/her healthcare provider.

Photographs: The taking, reproduction and use of photographs in connection with my diagnosis, care and treatment (including surgical procedures) at CORE Injury Management, PLLC is approved, provided my identity is not revealed. Photographs may include the use of videotapes, television and digital imaging. The images may become part of the medical record.

Consent to Treatment by Student Medical Professional: As a part of a policy of continuing medical education, CORE Injury Management, PLLC may have from time to time medical, nursing and paramedical students observing or participating in the care provided for its patients. I understand that this may include surgical procedures, x-ray or other medical imaging procedures, examination of tissue, and other aspects of my care. I further understand that at all times these activities will be under the supervision and approval of my physicians and/or other licensed health care professionals and will be at a level deemed appropriate and necessary by them, and I consent to the observation and participation of medical and paramedical students in the medical care provided for me while I am a patient at CORE Injury Management, PLLC.

Notice to Maternity Patients: My authorization today for my care and the care of my baby will apply to care I may receive today as well as future care related to my present pregnancy, up to and including my delivery.

Patient Rights and Responsibilities: I acknowledge the receipt of my Patient Rights and Responsibilities.

Notice to Outpatients: If the visit today is for a series of outpatient treatments, your authorization for outpatient care and services provided by CORE Injury Management, PLLC is required once per calendar year.

Receipt of Electronic Mail: I acknowledge that giving my email authorizes soley CORE Injury Management, PLLC to send my health promotions, patient care announcements and patient care surveys. Other than patient care surveys (which will be administered by our vendor), my information will not be sold or disclosed to any other third parties.

Patient Property: I am aware that CORE Injury Management, PLLC is not liable for the loss or damage of any personal property unless placed in a safe.

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I UNDERSTAND ITS CONTENT. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I CONSENT TO TREATMENT AND CARE AT CORE INJURY MANAGEMENT, PLLC.

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Printed name of Patient or Guardian/Representative | Relationship to Patient

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Signature of Patient or Guardian/Representative | Date