Cape Fear Center for Digestive Diseases, PA

CONSENT TO TREATMENT

I am a patient at **Cape Fear Center for Digestive Diseases, PA**. (CFCDD, PA). By signing this form, I consent to be treated by the providers of this practice.

My doctor needs more medical facts about my health. I, ________________________________, date of birth _________________ ask for and allow Dr. ____________________ and staff to give me the needed medical treatment and services that he or she recommended.

I understand that treatment and services may include:

- Lab tests,
- Screening tests (tests that can find an illness earlier, before a person shows signs of having the disease),
- Diagnostic tests (tests that show if a person has a certain illness or health problem), and
- Routine exams.

I understand that no promises have been made to me about the results of any treatment or services.

____ ____

Signature of Patient or Responsible Party Date

____ ____

Witness Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT

I, ___________________________________, hereby acknowledge that CFCDD, PA has given me the opportunity to read a detailed notice of their Privacy Practices. A copy is available in the clinic lobby, and on our website www.cfcdd.com, look under the For Patients tab.

Patient/Guarantor Signature* _______________________________________ Date _______________________________________

**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

If not signed, please provide a reason why the acknowledgment was not obtained.

____

Witness ____ Date ______________________________________

Staff Signature

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, ______________________________________, give permission for a representative from CFCDD, PA, to speak with family member(s) or companion(s) listed below regarding care or test results.

Name ____ Phone ______________________________________

Relationship ____

Name ____ Phone ______________________________________

Relationship ____

Is it OK to leave results or information on your voicemail/answering machine? ☐ Yes ☐ No

Is it OK to send results or information to you by mail? ☐ Yes ☐ No

Patient/Guarantor Signature* ____ Date ______________________________________

**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

ADVANCED DIRECTIVE

1. Do you have an Advanced Directive or Do Not Resuscitate Order (DNR)? Yes No
2. (If yes to #1) I will supply a copy of my Advance Directive in case of hospital transfer. Yes No
3. I understand that CFCDD does not honor Advance Directives. Yes No
4. I understand that in the event of an accidental needle stick, I will be required to have blood drawn for testing. Yes No

Signed ____ Date ______________________________________

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