NEXUS
Family & Maternity Care

General Consent for Care and Treatment

I have the right, as a patient, to be informed about my condition(s) and the recommended surgical, medical, or diagnostic procedure(s) to be used so that I may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. This consent provides Nexus Family and Maternity Care with my permission to perform reasonable and necessary medical examinations, testing, and treatment at this office or any other satellite office under common ownership.

I have the right to discuss the treatment plan with my provider about the purpose and potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my health care provider, I am encouraged to ask questions.

I voluntarily request a physician, a mid-level provider (e.g. Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist), and/or other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examinations, testing, and treatment for the condition(s) for which I seek care at this practice. I understand that if additional testing or procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I understand that I have the right to refuse any procedure(s) or treatment(s).

I allow Nexus Family and Maternity Care to file for insurance benefits to pay for the care I receive. I understand that:

- Nexus Family and Maternity care will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or if I do not have insurance.

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

_____	_____	_____
Signature	Full Name	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name	Date