## General Consent to Treatment and Right to Refuse Treatment

General Consent to treatment: By signing below, I, (or my authorized representative on my behalf) authorize Columbus Orthopedic & Sports Medicine Clinic and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. I also understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers.

Patient Name:______________________________ Date of Birth:_________________
(*Printed)*

Signature:______________________________ Date:________________________
(*patient/parent/conservator/guardian)*

## Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Columbus Orthopedic & Sports Medicine Clinic. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://www.columbusorthopedics.com or by requesting a copy from our health care team.

I acknowledge receipt of the *Notice of Privacy Practices.*

Signature:______________________________ Date:________________________
(*patient/parent/conservator/guardian)*

*For Office Use Only*

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative:__________________________ Date:__________

**Reasons why the acknowledgement was not obtained:**

Check Box if applicable.

Patient refused to sign

Other or comments: ____________________________________________________________

________________________________________________________________________