JONNA L. SCHMIDT, M.D., P.C.

Internal Medicine/Pediatrics

www.jonnaschmidtmd.com

456 Cross Street, P.O. Box 270
Hudson, Michigan 49247

Phone: 517-448-8918
Fax: 517-448-4085

General Patient Consent for Care Form

General Consent for Care:

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Jonna L. Schmidt, M.D., P.C. on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of Jonna L. Schmidt, M.D, and other employees under the direction of a Jonna L. Schmidt, M.D., as deemed reasonable and necessary.

I agree and acknowledge that Jonna L. Schmidt, M.D., P.C. is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Jonna L. Schmidt, M.D., P.C.

Telemedicine:

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

To the Patient:

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 recommend by your health care provider, we encourage you to ask questions. 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. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent:

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

_____ _____

Printed name of Patient (or Legal Guardian signing) Date

_____ _____

Printed name of patient (if under 18 years of age) Relationship to Patient

_____

Signature of Patient or Legal Guardian