ORTHOPEDIC ASSOCIATES OF LANCASTER, LTD

Experienced, Specialized Care

Patient Name: _____

DOB: _____

MRN: _____

Voluntary Consent to Treat

I do hereby voluntarily consent to permit any associated physician or assistant of Orthopedic Associates of Lancaster (OAL) to perform an examination and any diagnostic procedures, including such medical/surgical procedures as are necessary or advisable in their judgment for my medical care.

_____ Initial

Patient Unable to Consent

Forms must be filled out by POA, or person accompanying patient

If the above patient is unable to consent for treatment, please fill out the following information:

Person accompanying patient: _____, relationship: _____

☐ Nursing Home Residence (if applicable): _____

If POA is not physically present for visit, verbal consent was obtained from:

Name: _____ Relationship: _____

Consent obtained via (Circle): Phone email letter

Signature Patient Services Rep: _____

Date: _____ Time: _____

ACKNOWLEDGMENT OF RECEIPT OF AUDIO/VIDEO RECORDING POLICY & NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received the Audio/Video Recording Policy & Notice of Privacy Practices for OAL.

_____ _____ _____

Signature Print Name Date