ORTHOPEDIC ASSOCIATES OF LANCASTER, LTD

Experienced, Specialized Care

Patient Name: _____

DOB: _____

MRN: _____

VOLUNTARY CONSENT TO TREATMENT

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

MINOR CONSENT

Forms must be filled out by accompanying parent/guardian, or adult accompanying patient

If the above patient is a minor (<18 years of age), please fill out the following information:

Person accompanying patient: _____, relationship: _____

☐ Minor able to be seen at subsequent follow-up visits if accompanied by:

1) _____, relationship: _____

2) _____, relationship: _____

☐ Minor can be seen for subsequent follow-up visits by his/herself. _____ Initial

If parent/guardian/POA are not physically present for visit, verbal consent was obtained from:

Name: _____ Relationship: _____

Consent obtained by (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