

# Urgent Treatment Clinics

## Consent to Treatment

I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of the Urgent Treatment Clinic and its medical staff, designees, as may in their professional judgment be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make decisions, including the right to refuse medical and surgical procedures. I certify that I have read and understand the authorization given and I am the patient, or I am duly authorized by the patient to execute this consent and accept its terms. I also understand that this consent may be revoked at any time, except to the extent that action has already been taken, by the patient/duly authorized agent and will expire automatically **ONE** year from the date below.

## Advanced Directives

\_\_\_\_\_ **I have formulated** Advanced Directives (Living Will, Health Care Surrogate Declaration, Durable Power of Attorney), and request that these directives govern my course of care, in as much as is possible under state and federal law. I understand that it is my responsibility to provide the Hospital or UTC with a copy of my Advanced Directives and that those directives will not govern my course of care until they have been filed in my medical record.

\_\_\_\_\_ Advanced Directives **Attached**

\_\_\_\_\_ Advanced Directives **Not Attached**

\_\_\_\_\_ **I have not formulated** Advanced Directives (Living Will, Health Care Surrogate Declaration, Durable Power of Attorney), but I understand that it is my right to make decisions regarding my course of treatment, including the execution of advanced directives. I certify that I have read and understand the authorization given and I am the patient, or I am duly authorized by the patient to execute this consent and accept its terms. I also understand that this consent may be revoked at any time, except to the extent that action has already been taken, by the patient/duly authorized agent and will expire automatically **ONE** year from the date below.

## Pain Management Policy

We feel that for chronic pain management, the patient should be followed by his or her own doctor or by a pain management center for long term control of pain. Our doctors will not be prescribing any narcotics, nerve pills, muscle relaxants, and etc. for any patient on the first or subsequent visit. This office issues narcotic prescriptions only as a last resort and only for a very short term for those who require them for acute injuries or other medical conditions. If you have any questions, please do not hesitate to ask a staff member.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ SS # \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date