Patient Name: ________________________________
Patient DOB: ________________________________

Our Lady of the Lake Physician Group
Lourdes Physician Group
St. Francis Medical Group

GENERAL CONSENT FOR TREATMENT

I consent to and authorize the physician(s), physician assistant(s), nurse practitioner(s), resident physician(s), healthcare student(s), and clinical staff to provide diagnostic procedures and medical treatment including, but not limited to minor procedures and routine services deemed necessary at the time of the office visit, to me or the patient named on this form. I understand that the practice of medicine is not considered exact science, and acknowledge that no guarantees have been made to the patient named on this form.

Medical Education*
I agree that care may be provided by student nurses, technicians, therapists, interns, residents, fellows and other providers and observers, which are supervised by qualified faculty in accordance with organizational policies.

Photography and Other Recordings*
I consent to photographs, audio and video recordings, digital or other images that may be recorded to document my care. I understand that these images may be used for case study and research. I understand that these images will be stored in a secure manner and will be released when requested for non-treatment reasons, only upon written authorization by me, or my legal representative. I consent to having part of my care be provided by use of video equipment, without the physician being physically present in exam room.

Authorization for Healthcare-Related Calls, Texts and E-mails
I, the undersigned, hereby authorize and consent to employees, agents, representatives, affiliates, business associates, and/or designees contacting me using prerecorded/artificial voice messages and/or automatic dialing services at any telephone number (including a wireless telephone) that I provide. This consent and authorization will apply to text messages sent to the wireless numbers I provide and also to e-mails using any e-mail address that I provide. I understand that texting or emailing to the numbers and addresses I provide may not be secure. This consent and authorization will apply to the current visit and any future visits. This consent and authorization is valid until revoked by me, in writing, by certified mail sent to the following address:

FMOLHS
ATTN: Customer Service Team
5959 S. Sherwood Forest Blvd.
Baton Rouge, LA 70816

If I am incapacitated and unable to provide my consent and authorization as discussed above, such consent and authorization may be given by any of those persons who are authorized to consent to surgical or medical treatment on my behalf pursuant to La. R.S. 40:1299.53. Such third party's consent and authorization, however, is only valid for the period of my incapacitation.

Specimens
Further, I authorize and consent to the preservation, examination, testing, retention, use, including, without limitation, the use for scientific, diagnostic, therapeutic or educational purposes, or disposal at its discretion, of any specimens, tissues, materials, or substances which may be removed during a diagnostic procedure, therapeutic intervention or medical treatment.

Devices
I consent to disposal of explanted medical device unless I specifically request it to be retained prior to procedure.

Blood
Further, I understand that should any medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including, without limitation, Hepatitis B and C as well as HIV/AIDS. I understand that I can decline HIV testing if it is for routine screening. I understand that state law requires the hospital and/or physician to report certain infectious diseases including sexually transmitted diseases to the state’s Department of Health.

Patient Name: ______________________________
Patient DOB: ______________________________

These sections may or may not apply to this clinic. If you have any questions, please discuss with your provider.

By signing below, I acknowledge that I have read this form, and fully understand and accept its terms and conditions. I have had a chance to ask any questions that I might have.

Patient Name (print): ______________________________

Patient Signature: ______________________________

Date: ______________________ **Time:** ______________________

If the patient is a minor, the person authorized to consent should sign below.

Authorized Person for Consent Name (print): ______________________________

Authorized Person for Consent Signature: ______________________________

Date: ______________________ **Time:** ______________________

If the patient is not a minor, but is unable to consent, the person authorized to do so should sign below.

Authorized Person for Consent Name (print): ______________________________

Authorized Person for Consent Signature: ______________________________

Date: ______________________ **Time:** ______________________

If the patient is a minor or otherwise unable to provide consent, the signatures above must be observed by witnesses, who must sign below.

Witness Name (print): ______________________________

Witness Signature: ______________________________

Date: ______________________ **Time:** ______________________

Second Witness Name (print): ______________________________

Second Witness Signature: ______________________________

Date: ______________________ **Time:** ______________________