Isabella Citizens for Health, Inc.

General Consent for Treatment

I hereby and voluntarily consent to authorizing the Center's health care providers to provide health care services to me at the Center's service locations. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medication; and procedures and treatments prescribed by the Center's health care providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that there is a separate consent for telehealth visits.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as I am a patient of the Center, until I withdraw my consent, or until the Center changes its services and asks me to complete a new consent form.

I understand that my treatment, payment, enrollment, and eligibility for benefits aren't conditioned by my signature on this form.

<u>Consent Provisions</u>

My signature on this acknowledgement form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that midlevel providers (Physician Assistants and Advanced Practice Registered Nurses) may be involved in my treatment I consent thereto.
4. I understand that I may be asked to sign a separate informed consent for certain treatment(s) that require such.
5. I hereby voluntarily give my consent to treatment at the Center.

_____ _____

Patient Signature Date

Revised Jan 17, 2024