1900 Riverside Parkway
Lawrenceville, GA 30043
: 770-237-3475
:1-877-JOINT-50
: 770-237-3756
:www.sportsmedsouth.com

Sports Medicine South
Atlanta's Orthopaedic & Sports Medicine Specialists

General Consent Form

PATIENT CONSENT TO MEDICAL TREATMENT

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

PROCEDURES: During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

NO GUARANTEE OF RESULTS: Sports Medicine South physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release Sports Medicine South, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Sports Medicine South or its employees.

PROVIDING ACCURATE INFORMATION: I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Sports Medicine South, LLC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to Sports Medicine South, LLC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sports Medicine South, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Sports Medicine South, Attn: Kaylee Rosenberger, 1900 Riverside Parkway, Lawrenceville, GA 30047 or by calling 770-237-3475 x 115.

With my consent, Sports Medicine South, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

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With my consent, Sports Medicine South, LLC may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder cards and patient statements.

I have the right to request that Sports Medicine South, LLC restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Sports Medicine South, LLC may decline to provide treatment to me.

By signing this form, I am consenting the Sports Medicine South's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

Signature of Patient or Legal Guardian: _____

Patients Name: _____ Date: _____

Print Name of Patient or Legal Guardian: _____