

CONSENT TO MEDICAL TREATMENT

**Family Care Associates
of Blair County**
Quantum HealthCare Services LLC
James Frommer DO
125 Carson Valley Road
Duncansville, PA 16635
Phone: 582-465-7008

Patient Name (Print): _____ **DOB:** _____

I, the above-named patient, hereby give my informed consent to James Frommer DO and any other healthcare providers who may be involved in my care to provide medical treatment, examinations, procedures, and diagnostic tests as deemed necessary for my health condition.

- ! I understand that the purpose of this medical treatment is to address and manage my health condition, and that there may be alternative treatments or procedures available that have not been recommended to me.
- ! I understand that the healthcare providers involved in my care may need to disclose my protected health information to other healthcare providers involved in my treatment, for the purpose of coordinating my care.
- ! I understand that the healthcare providers will make every effort to maintain the confidentiality of my protected health information, but that there may be certain situations where disclosure may be required by law, such as reporting of communicable diseases or suspected child abuse.
- ! I have had the opportunity to ask questions about the proposed treatment, and my questions have been answered to my satisfaction. I have been given a reasonable explanation of the risks, benefits, and alternatives to the proposed treatment, and I understand the potential consequences of refusing treatment.
- ! I understand that I have the right to revoke this consent at any time, except to the extent that action has been taken in reliance on it.

I certify that I have read and fully understand the above information, and that I have had an opportunity to ask questions about the proposed treatment. I voluntarily consent to receive medical treatment, examinations, procedures, and diagnostic tests as deemed necessary by my healthcare providers.

Patient Signature: _____ **Date:** _____

Representative Name: _____ Relationship:

Provider Signature: _____ Date:
