3375 Lake Ridge Dr. Dubuque, IA 52003
Phone: (563)-207-8932 Fax: (563) 207-8935

General Consent for Care and Treatment Consent

You have the right, as a patient, to be informed about your condition and the recommended medical care, chiropractic care, mental health care, physical therapy, acupuncture and/or diagnostic procedures to be used so that you may make the decision whether or not to undergo any suggested treatment, therapy or procedure after knowing the benefits, risks and alternatives involved. At this point in your care, no specific evaluation or treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s), and to proceed with the appropriate treatment plan.

This consent provides us with your permission to perform reasonable and necessary evaluations, medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to ongoing treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services and/or to request further explanation at any time.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any therapy, treatment, or test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

You voluntarily request a Physician, Chiropractor, Acupuncturist, Mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), Physical Therapist, Mental Health providers and any other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. You understand that if additional testing, invasive or interventional procedures are recommended, you may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________	______________________________	______________
Sig. of Patient or Parent/Gaurdian	Printed name	Date