PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby Voluntarily consent to and authorize medical care and treatment by Neighborhood Urgent Care, through Its individual physicians, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the physician/provider.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician /provider or Neighborhood Urgent Care.

I acknowledge that I have received a copy of Neighborhood Urgent Care's Notice of Privacy Practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.neighborhooduc@yahoo.com. I consent to be called on my cell phone concerning healthcare services rendered to me.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Neighborhood Urgent Care. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____ _____

Patient's Signature Patient's Name (Printed)

Patient, _____ is a minor, or is unable to sign above because: _____
(Name Printed)

_____ _____

Person Giving Consent Relation to Patient

_____ _____

Witness Date