General Consent for Care and Treatment

I provide consent to New York City Physician, P.C. dba NYC Home Medical (“NYC Home Medical”), and its staff and healthcare providers, to perform reasonable and necessary medical examinations, testing and treatment. This may include but is not limited to: telehealth care; physical or other diagnostic examinations (e.g., ultrasound, electrocardiogram, CLIA-waived testing); laboratory procedures; blood draws; intravenous and intramuscular and intradermal and subcutaneous injections and infusions; oral and ocular and intranasal and parenteral and rectal medications; and prescription medications).

I acknowledge that I have received no warranties or assurances with respect to any benefits which are hoped to be realized, or consequences which may result, from any of the examination(s), procedure(s) or treatment(s) which may be performed or used. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury and even death.

I consent to the photographing and/or videotaping of the appropriate portions of my body, which are pertinent to showing my physical condition, for medical or educational purposes, provided reasonable precautions are taken to conceal my identity.

By signing below, I agree that (1) this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment with all of the healthcare providers of NYC Home Medical. The consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services.

I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any treatment, test, medication, or procedure ordered. If I have any concerns regarding any of these as recommended by my healthcare provider, I am able to and encouraged to ask questions.

I voluntarily request a Physician, and/or Nurse Practitioner, Physician Assistant, or Nurse, and 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. I understand that if additional testing, invasive or interventional procedures are recommended, I will 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.

Signatures

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Name of Patient or Legal Representative Relationship to Patient (If Legal Representative)