Orchard Medical Associates, L.L.C.

General Consent for Care and Treatment

I consent to and authorize personnel within Orchard Medical Associates, L.L.C. to administer care and treatment to me and to perform diagnostic and therapeutic procedures and tests and other care and treatment considered necessary or advisable by the providers who attend to me.

I consent to and authorize Orchard Medical Associates to send copies of any of my protected health information to my care providers for the purpose of my medical treatment. In addition, I consent and authorize Orchard Medical Associates to use and disclose my protected health information for payment and health care operations as defined by HIPAA.

I understand that the practice of medicine, including surgery, is not an exact science, and I agree that no guarantees have been made to me concerning the results of my treatment.

I understand that this consent will be valid for on (1) year from this date for any care rendered in this office.

I have read this consent form carefully and have had all of my questions answered, I understand this consent form and agree to its terms.

_____

Signature of Patient or Authorized Representative

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Signature of Patient or Authorized Representative

Date: _____