Facility: **KINGS COUNTY HOSPITAL CENTER**

NYC HEALTH+ HOSPITALS

(GENERAL CONSENT FOR TREATMENT)

Chart No: [redacted]

Name: [redacted]

Unit: KINGS COUNTY ADULT ED

(FORM A)

For patients seeking in-patient, out-patient and/or emergency room services.

1. I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine dental and medical care, including photographs and closed-circuit monitoring for treatment purposes, and vaccination. I understand that these services will be provided to me by physicians, dentists, nurse practitioners, midwives, physician assistants and other health care providers, some of whom may be in training. I have not been given any guarantees as to the results of the services I will receive.
2. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.
3. I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking X-rays, use of local anesthesia and other non-invasive procedures.

[redacted]

Signature of Patient or Parent/Legal Guardian of Minor Patient

If the patient cannot consent for themself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

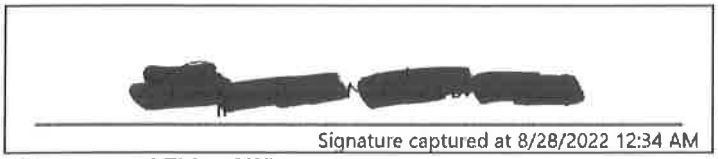
Signature of Health Care Agent/Legal Guardian
(Place a copy of the authorizing document in the medical record)

Signature and Relation of Surrogate

WITNESS:

I, Ingrid M. McLawrence, am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient, or an authorized representative, voluntarily sign this form ☐, **OR** consent to treatment telephonically ☐.
(Check one box.)

I, Ingrid M. McLawrence, am a staff member who is not the patient' s physician or authorized health care provider and I have witnessed that the patient is **unable** to sign this form ☑ ; **OR** that the patient or an authorized representative, **refused** to sign this form ☐ . **(Check one box.)**



Signature and Title of Witness

INTERPRETER: (To be signed by the interpreter if the patient required such assistance)
I have provided an accurate and complete interpretation of an explanation/discussion of this form between the staff and/or health care provider(s) and the patient or the patient's authorized representative.

Signature of Interpreter (if present), ID# and Agency Name

An electronic signature has the same validity and effect as a handwritten signature.