## North Central Health Care Person centered. Outcome focused.

## CONSENT FOR SERVICES

Name:	_ DOB:	MRN:
Consent Date:	_ Expiration Date	e:
I understand that by signing this agreement, I consent to all General care and/or routine services, including evaluation, therapies, nursing care, diagnostic testing, mental health, and drug and alcohol treatment provided under the general or specific instruction of my health care provider(s).		
I understand that my physician(s) or other health care providers may be accompanied and/or assisted by students, interns, and residents during my care. I consent to the presence and/or participation in my treatment by these persons while under the direction or supervision of my physician(s) or other authorized health care providers.		
Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and treatment at any time by providing a written request to the treating provider.		
Expiration of Consent: This consent to treat will expire 15 months from the date of signature. I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment and understand that special consent forms may need to be signed for specific procedures.		
☐ The client verbally consents to care, given current presence of COVID-19 in the community and the nature of the visit performed off site NCHC will obtain client/parent/guardian signature at the next in-person visit at NCHC.		
Signature – Patient/Client	Date/Time Signed	
Signature – Parent/Guardian/Other	Relationship	Date/Time Signed