WELLSTAR SUMMIT SURGICAL
CONSENT FOR TREATMENT
AND HEALTHCARE OPERATIONS

Patient's Name: _____

Patient's Address: _____

_____

Patient's DOB: _____ S.S.# _____

I hereby voluntarily consent and authorize such treatments, procedures, diagnostic and/or laboratory test ordering or examinations performed in the office as ordered by the Physician attending me, or if more than one, any one of them
Please check the appropriate box:

□ An adult consenting for himself/herself □ A parent consenting for his/her child

□ A guardian consenting for his/her ward □ An adult consenting for his/her parent

□ A person temporarily standing in loco parentis, formally serving or not, consenting for the minor under his/her care

In the course of normal business operations, WellStar Summit Surgical may need to contact out patients by various methods. These contacts may include, but are not limited to: leaving messages regarding appointments/missed appointments, prescriptions refills, surgery scheduling, financial related calls, and Nurse/Physician call backs. Please check all of the following means we may contact you. **Please be aware that an employee's name, Practice/Physician name, and telephone number will be left if a live person is not reachable.**

□ May leave a message on home voicemail/answering machine.
□ May leave a message with secretary/answering service/ work voicemail/ answering machine.
□ May contact via cellular phone/pager, and/or leave a message on it.
□ May leave a message with spouse/significant other, child, or other relative
Please list names of above persons we may leave brief information with:

_____, and/or _____

Signature of Consenting Person: _____

Printed Name: _____

Date: _____

Witness: _____