INFECTIOUS DISEASE ASSOCIATES OF TAMPA BAY
INTERNATIONAL TRAVELERS CLINIC OF TAMPA BAY

GENERAL CONSENT TO TREATMENT

I understand that I may have a health problem requiring evaluation, diagnosis, and treatment. I voluntarily consent to medically necessary evaluation and treatment of my health problem provided by a physician or advanced practice registered nurse (APRN).

I understand that I have the right to be informed about any condition identified and the options for recommended medical or diagnostic procedures to be used.

I understand that I can decide whether to undergo any suggested treatment or procedure after being informed of the potential benefits and risks involved.

I understand that I can ask any questions or discuss any concerns about any suggested treatment or procedure at any time.

I understand that the provision of health care services is not an exact science. I acknowledge that no guarantees have been made to me as to the results of examinations or treatments to be provided to me.

I understand that by signing below I am indicating that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at any location of Infectious Disease Associates of Tampa Bay.

I certify that I have read and fully understand the above statements and that I am competent and authorized to execute this Consent to Treatment.

_____ _____

Patient/Personal Representative Signature **Date**

_____ _____

Printed Name of Patient or Representative **Date**

Acknowledgement of Receipt of Infectious Disease Associates of Tampa Bay's Payment and Financial Policy & Assignment of Benefits, Notice of Privacy Practices, & Florida Department of Health's Alternatives to Opioids Pamphlet.

By signing below, I acknowledge that I have received/reviewed the following:

1.) Infectious Disease Associates of Tampa Bay's **Payment and Financial Policy & Assignment of Benefits**

2.) Infectious Disease Associates of Tampa Bay's **Notice of Privacy Practices**

3.) Florida Department of Health's **Alternatives to Opioids Pamphlet**

_____ _____

Patient/Personal Representative Signature **Date**

_____ _____

Witness **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:

_____