



DocOrigin
Healthcare

Eclipse Corporation
100 Concourse Pkwy - Suite 120,
Hoover, AL 35244
Phone +1 678-408-1245



Consent Forms

Patient: Patient H Sample
Provider's Pt ID: 6910828
Attachment Control Number: XA728302

PATIENT INFORMATION

Goldie R Chisolm

(706) 296-9964
1195 Holly Street
Athens, Georgia(GA), 30601
United States

Birth Date: 21/2/1972
Weight: 62.69
Height: 157

EMERGENCY CONTACT

Bertie C Rowell

4026 Hickory Lane
Washington, Washington DC(DC), 20036
United States

Home phone: (202) 452-9485
Work phone: (323) 650-1865

CONSENT FORM

I, **Goldie R Chisolm** hereby give my informed consent for medical treatment and procedures to be administered by the healthcare professionals at ACME Hospital

I understand and acknowledge the following:

- 1. Nature of consent:** I understand that by signing this form, I am authorizing **ACME Hospital** and its healthcare providers to provide medical treatment, conduct diagnostic tests, and perform necessary procedures to diagnose and treat my medical condition.
- 2. Nature of treatment:** I acknowledge that **ACME Hospital** may employ a variety of medical treatments, including but not limited to examinations, diagnostic tests, medical procedures, surgeries, administration of medication, and the use of medical devices. I understand that alternative treatments, risks, and potential complications will be discussed with me before any procedures are performed.
- 3. Risks and benefits:** I understand that all medical treatments and procedures carry certain risks and potential benefits. While **ACME Hospital** will take necessary precautions to minimize risks, I acknowledge that no guarantees or assurances can be made regarding the outcome of any treatment or procedure.
- 4. Privacy and confidentiality:** I acknowledge that **ACME Hospital** committed to protecting the privacy and confidentiality of my personal health information in is accordance with applicable laws and regulations. I authorize the collection, use, and disclosure of my health information for the purposes of treatment, payment, and healthcare operations.
- 5. Financial responsibility:** I understand that I am financially responsible for all medical services rendered by **ACME Hospital** I agree to pay all charges for services not covered by my insurance, including deductibles, co-pays, and any outstanding balances.

Signature

Date (yyyy/mm/dd)