

CONSENT FOR TREATMENT

San Antonio NP Associates
Primary Care Services

Patient Name: _____ **Date of Birth:** _____

I voluntarily consent to the rendering of medical care, treatment, and/or related services as my provider(s), in their professional judgment, deem necessary. I understand that in the event of a medical or psychiatric emergency that may be life-threatening, it may become necessary for the practice to provide emergency treatment and/or arrange transfer to a hospital or higher level of care.

I understand that I may refuse or withdraw consent for any treatment or procedure at any time. I acknowledge that no promises or guarantees have been made regarding the results of my care or any procedures performed. I understand that if I choose to stop treatment, I remain financially responsible for services already rendered and that discontinuing care may result in loss of services or other consequences (including legal or court-ordered requirements, if applicable).

My consent includes, but is not limited to, medical examinations, diagnostic testing, laboratory services, procedures, and treatments, including testing for sexually transmitted infections and/or HIV (unless separate consent is required by law), wound care (including evaluation, cleaning, debridement, and dressing changes), minor surgical procedures (such as stitches), cast application or removal, and vaccine administration. I understand that care may be provided by clinical staff acting under the supervision and direction of my provider.

If I request or initiate a telehealth visit (a “virtual visit”), I consent to participate in telehealth services and understand that I may terminate the visit at any time.

I understand that care may be provided by a Nurse Practitioner or other licensed clinician, with physician collaboration or supervision as required by Texas law.

I understand that my health information may be shared with my insurance carrier or other third-party payers for purposes of treatment, payment, and healthcare operations. I acknowledge receipt of the practice’s Notice of Privacy Practices, which describes how my protected health information (PHI) may be used and disclosed, my rights regarding that information, and the practice’s right to revise those practices as permitted by law.

I consent to the use of clinical photographs or images for purposes of treatment, documentation, and continuity of care. Such images will be maintained as part of my medical record and protected in accordance with HIPAA and applicable privacy laws.

I acknowledge that I have read and understand this Consent for Treatment and have had the opportunity to ask questions.

Patient Signature: _____ **Printed Name:** _____

Date: _____