

CONSENT FOR CARE

I UNDERSTAND AND AGREE TO THE FOLLOWING:

- **MEDICAL TREATMENT:** I consent to and permit my health care team to provide treatment and care as they deem necessary and appropriate, including but not limited to, tests (including HIV tests), examinations, anesthetics and other medications, immunizations, x-rays, and medical and surgical treatment and other treatments. I understand my health care team consists of physicians, nurses and other health care professionals (including those in training). I understand that my care is under the control of my attending physicians, who may be employees of EvergreenHealth or independent physicians. I understand that EvergreenHealth is not liable for the acts or omissions of independent physicians, including those occurring from following their instructions. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the result of treatment or examination at EvergreenHealth.
- **PHOTOGRAPHS:** I understand that photographs, video, or other images of me may be created and used in connection with my diagnosis, care and treatment (including surgical procedures) at EvergreenHealth and that these images may become part of my medical record.
- **PERSONAL VALUABLES:** I understand that, if I am admitted to EvergreenHealth Medical Center, EvergreenHealth will not be liable for loss or damage to any money, jewelry, glasses, dentures, documents or any other personal property unless I have placed such items in the safe that EvergreenHealth maintains for safekeeping and I have received an itemized receipt from EvergreenHealth identifying the items.
- **HOME CARE PATIENTS:** I agree to allow home visits by EvergreenHealth Home Care Services (EHCS) employees as well as Washington State, Medicare and other Accreditation surveyors for the purpose of evaluating the care that is provided by EHCS's employees.

By signing below, I agree that I have read this form and/or had it explained to me. I have asked any questions about any part of the form that is unclear to me and understand the answers. I agree to the terms stated and will receive health care from EvergreenHealth. If I am signing on behalf of a patient, whether as the patient's parent, guardian, or other representative, I am authorized to sign on behalf of the patient.

Patient Signature: _____ Date: _____

Printed Name: _____ Time: _____

If signed by a person other than the Patient, my relationship to Patient is:

- | | | |
|---|--|---|
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Health Care Power of Attorney | <input type="checkbox"/> Parent |
| <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Adult Child | <input type="checkbox"/> Adult Brother/Sister |

For Minor Patients:

- | | | |
|---------------------------------|---|--|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Guardian/legal custodian | <input type="checkbox"/> Court-authorized person for child |
|---------------------------------|---|--|

Other (please describe): _____

Patient Name: _____

Date of Birth: _____

FIN #: _____