**NYC –Metro Physician Services PC**

**Consent for Service**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby consent and authorize NYC –Metro Physician Services PC, its agents and associates to provide care and treatment to me in my home. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at your home or any other satellite location. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

**Authorization For Release of Information**

I hereby consent and authorize NYC –Metro Physician Services PC to release and receive protected health information for the purposes of treatment and healthcare operations. The exchange of information may occur between, but is not limited to, physician, other healthcare providers and regulatory and/or accrediting reviewers.

**Supplies**

I understand that I will be informed of any DME (Durable Medical Equipment) that is recommended by the care team and that right to decide not to have the equipment ordered. I understand that this equipment may be paid for by my health plan (Medicare, Medicaid). I will be informed of any copays and/or charges I am liable for before equipment is ordered

**Consent**

This consent to Service is applicable to NYC –Metro Physician Services PC. I understand what I have read what was explained to me and agree to the agreement. Additionally, I understand that either party may terminate this agreement for any reason and/or any time.

Signature of Patient or Representative Date

Name of Patient or Representative Relationship to Patient

Name of Witness

Signature of Witness Date