HAMPTON PSYCH NPs, (HPN)

GENERAL CONSENT

I consent to evaluation and treatment of the condition for which I, my child or dependant, have come to HPN , and authorize the physicians and other health care providers affiliated with HPN to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by HPN I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at HPN . I have had an opportunity to discuss it, and any questions I have had have been answered to my complete satisfaction.

Date

_____

Signature of Patient, Parent or Legal Guardian

Date

_____

Signature of Witness