CONSENT

NMC health®

PO Box 308 | Newton, KS 67114

NMC HEALTH CLINICS CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that you provide at least 24 hours' notice.

Patients who fail to cancel an existing appointment without sufficient notice, or do not attend a scheduled appointment, will be considered a **NO SHOW**. Patients who No Show three (3) times may be dismissed from the practice, and may be denied any future appointments.

Patients who are greater than 10 min late to an appointment may be asked to reschedule.

Please sign that you have read, understand, and agree to this Cancellation and No show Policy.

_____ _____ _____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

NMC HEALTH CLINICS CONSENT TO TREATMENT

I consent to examination and/or treatment provided by NMC Health clinics under the instructions of a physician. This may include radiologic examination, laboratory procedures, anesthesia, medical and surgical treatment, or other services provided by the clinics. I understand that additional consents may be required for specific procedures and/or treatments.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in the clinic/hospital. To enhance the efficiency and documentation of your visit, an AI-assisted program may be used to dictate notes and information.

In the event that an individual is suspected to be exposed to my blood or body fluid, I consent to be tested to determine whether or not my blood contains contagious viruses, including Hepatitis B and Human Immunodeficiency Virus. I understand there will be no charge to me for such laboratory testing done as a result of exposure.

This consent has been fully explained to me and I understand its conditions.

Patient Signature: _____ Date: _____

Agent/Representative/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____

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