LENOX MEDICAL CLINIC

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General Consent to Treatment and Procedures

PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING.

PURPOSE OF THIS CONSENT

This form provides your general consent for Lenox Medical Clinic and its healthcare providers to perform evaluations, diagnostic tests, and treatments that your provider determines are medically appropriate during the course of your care.

PROCEDURES COVERED BY THIS CONSENT

1. NEEDLE STICKS AND INJECTIONS

This includes shots, vaccinations, intravenous lines, and similar procedures. Potential risks include, but are not limited to: nerve damage, infection, infiltration, scarring, loss of limb function, or in rare cases, paralysis. Alternatives may include oral, rectal, nasal, or topical medications where clinically appropriate.

2. PHYSICAL EXAMINATIONS AND ASSESSMENTS

This includes vital signs, internal body examinations, wound care, range of motion checks, and similar assessments. Potential risks include, but are not limited to: allergic reactions, infection, musculoskeletal injury, or temporary discomfort.

3. ADMINISTRATION OF MEDICATIONS

Medications may be administered by mouth, injection, topically, or by other appropriate routes. Potential risks include, but are not limited to: allergic reactions, side effects, or adverse drug interactions.

4. BLOOD DRAWS AND SPECIMEN COLLECTION

This includes laboratory blood draws, urine collection, and tissue samples for diagnostic testing. Potential risks include, but are not limited to: bruising, bleeding, infection, nerve irritation, or temporary discomfort at the collection site.

5. INSERTION OF TUBES OR DEVICES

This includes procedures such as bladder catheterization or other necessary clinical interventions. Potential risks include, but are not limited to: infection, discomfort, or injury to surrounding tissue.

YOUR RESPONSIBILITIES

To support safe, effective care, I agree to:

- Provide accurate, complete, and up-to-date medical history and medication information
- Inform my provider of all known allergies and previous adverse reactions
- Inform my provider of any changes to my health, medications, or insurance status
- Ask questions any time I do not understand a recommended procedure or treatment

PERSONAL PROPERTY

Lenox Medical Clinic is not responsible for the loss, theft, or damage of any personal belongings brought to the office, including but not limited to money, jewelry, hearing aids, eyeglasses, or dental devices. Please leave valuables at home or secured in your vehicle.

IMPORTANT LIMITATIONS

The practice of medicine is not an exact science. No guarantees or assurances can be made regarding the outcome of any procedure, test, or treatment. Some healthcare professionals involved in your care may be independent contractors who are individually responsible for their own clinical actions.

YOUR RIGHTS

You have the right to:

- Ask questions about any procedure before it is performed
- Refuse any specific procedure or treatment
- Request additional information or a second opinion at any time
- Request that your provider explain risks and alternatives before proceeding

If you have questions about any planned procedure, please ask your provider before the procedure begins. Your provider may request that you sign an additional procedure-specific consent form when appropriate.

MEDICATION POLICY ACKNOWLEDGMENT

Please read each item below carefully. By signing this form, you acknowledge and agree to all of the following medication policies of Lenox Medical Clinic.

1. Prescription Refills — Processing Time

I agree to allow a minimum of **3 business days** for all prescription refill requests to be processed. I understand that a follow-up visit with my physician may be required before a refill can be authorized. Refill requests submitted on weekends or holidays

will begin processing on the next business day. **I will not wait until I have run out of medication before requesting a refill — it is my responsibility to request refills in a timely manner.**

2. How to Request a Refill

Refill requests may be submitted through any of the following channels:

- **Healow Patient Portal** — Submit a refill request through your Healow patient account
- **Phone** — Call our office at 770-458-8497 during normal business hours
- **Pharmacy Fax** — Ask your pharmacy to fax a refill request directly to our office at 770-220-2839

3. Taking Medications as Prescribed

I agree to take all medications exactly as instructed by my provider. I understand that I am **not** permitted to change my dosage, alter my medication schedule, or stop a prescribed medication without first speaking with my provider.

4. No After-Hours Refills for Controlled Substances

Narcotic and non-narcotic controlled substance prescriptions **will not** be called in, faxed, or authorized after hours. All controlled substance refill requests must be submitted during normal business hours.

5. Lost or Misplaced Prescriptions

I understand that Lenox Medical Clinic **will not** replace prescriptions that have been lost, misplaced, or reported stolen. Please store all prescriptions securely.

6. Urine Drug Screening

I understand that if I am prescribed controlled medications, Lenox Medical Clinic may occasionally require a urine drug screen to ensure my safety and confirm compliance with my prescribed treatment plan. I agree to comply with any such request.

7. No Sharing, Trading, or Selling of Medications

I agree that I will **not** give, trade, sell, or otherwise transfer any prescribed medication to another person. Doing so may be a violation of state and federal law and will result in immediate discharge from this practice.

8. Prescription Fraud — Immediate Termination and Reporting

I understand that altering or forging a prescription is a felony under Georgia law. Any suspected forgery, alteration, or fraudulent use of a prescription will be reported to the appropriate authorities and will result in immediate discharge from this practice.

9. Obtaining Controlled Substances from Other Providers

If I am receiving controlled substances from Lenox Medical Clinic, I agree not to obtain the same or similar controlled substances from any other provider without the prior knowledge and approval of my Lenox Medical Clinic provider. Failure to disclose concurrent controlled substance prescribing will result in immediate discharge from this practice.

10. Driving and Operating Heavy Machinery

I understand that many medications — including narcotics and other controlled substances — may impair my ability to drive or operate heavy machinery. I am aware that choosing to drive while impaired by medication may result in a DUI charge and poses a serious risk to myself and others. I accept full responsibility for any decision to drive or operate machinery while taking such medications.

11. No Alcohol with Narcotic Medications

I agree that I will **not** combine any narcotic or controlled substance medication with alcohol consumption. Combining these substances can cause serious injury or death.

12. Appointment Compliance

I understand that keeping scheduled appointments is my responsibility and is necessary to maintain my prescriptions. Failure to keep recommended follow-up appointments may result in prescriptions not being renewed until I am seen by my provider.

By signing this form, I acknowledge that I have read, understand, and agree to all medication policies stated above. I understand that noncompliance with these policies may result in discharge from Lenox Medical Clinic with 30 days notice, or immediate discharge for violations involving prescription fraud, diversion, or controlled substance misuse.

By signing this form, I confirm that I have read and understand this General Consent to Treatment. I consent to the evaluation and treatment of my condition(s) by the providers at Lenox Medical Clinic as they may deem medically necessary, including procedures that may not be specifically anticipated at the time of this consent.

_____. _____ _____

Signature of Patient or Authorized Representative *Printed Name* *Date*

_____ _____

Relationship to Patient (if not patient): *Reason patient unable to sign (if applicable):*