General Consent to Treat and Evaluate

LINCOLN NEPHROLOGY & HYPERTENSION PC

7401 O Street, Lincoln, NE 68510 | 402-484-5600 | Fax: 402-484-5630 | lincolnnephrology.com

I, _____, give my permission to be evaluated and treated by the staff of Lincoln Nephrology & Hypertension (LNH). I understand that information about my treatment and care will be kept confidential. In the course of treatment and evaluation, I may require testing that includes history taking; physical examination; and examination of blood, urine, and/or tissue. Ambulatory blood pressure monitoring (24 hour monitor) may be performed. These results will be interpreted by the physicians of LNH and results relayed to me in an appropriate and confidential manner. In the course of my evaluation and treatment, testing for Human Immunodeficiency Virus (HIV) may be necessary. I understand I have the right to refuse testing for HIV infection. Treatment may also be offered by LNH which may include recommendation for care, administration of injection, and prescription of medications. Questions about diagnosis and treatment options should be addressed to the physicians of LNH.

- OR -

I _____ representing the patient:

_____

HAVE HAD THIS CONSENT FULLY EXPLAINED TO ME. I HAVE READ AND UNDERSTAND IT FULLY, AND I ACCEPT ITS TERMS AND CONDITIONS.

_____ _____

Patient Name Person Authorized for Consent

_____

Relationship to Patient

Reason patient is unable to sign:

_____

_____

_____

Date: _____

Except when otherwise authorized by law, authorization must be signed by the patient or, in the case of a mentally incompetent patient, by the legal guardian of the patient. In case of a minor, the authorization, except in situations when only a minor's signature is required, shall be signed by the patient.

Privacy Notice Written Agreement

☐ I have received the Lincoln Nephrology & Hypertension Notice of Privacy Practices

Patient Signature: _____

Date: _____