

PROGRESSIVE MEDICAL GROUP, INC.
General Consent for Evaluation and Treatment

5434 W Capitol Drive, Suite 1, Milwaukee, WI 53216
Phone: 414-251-3500 | Fax: 414-251-3504
Email: progressivemedical20@gmail.com

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

City/State/ZIP: _____

Phone: _____

Email: _____

1. CONSENT FOR MEDICAL EVALUATION AND TREATMENT

I voluntarily consent to receive medical evaluation, diagnosis, treatment, and health-care services from **Progressive Medical Group, Inc. (PMG)** and its physicians, nurse practitioners, nurses, medical assistants, and other appropriately credentialed or supervised health-care professionals involved in my care.

I understand that my care may include, when medically appropriate:

- Medical history and physical examination
- Preventive and wellness services
- Annual physical examinations and Medicare wellness visits
- Evaluation and treatment of acute illnesses and injuries
- Management of chronic medical conditions
- Pediatric and adult primary care
- Laboratory testing and diagnostic services
- Medication management and prescription services
- Referrals and coordination of care with specialists
- Health counseling, education, and preventive care
- Telehealth services when appropriate

- Other medically appropriate services recommended by my health-care provider

I understand that the specific treatment recommended for me will depend upon my medical condition, history, examination findings, and clinical needs.

2. INFORMED CONSENT TO RECOMMENDED CARE

I understand that medical care may involve benefits, risks, side effects, complications, alternatives, and the possibility that a treatment may not achieve the desired result.

My health-care provider will explain the nature of recommended treatment and, when appropriate, the material risks, benefits, alternatives, and consequences of refusing treatment.

I understand that I have the right to ask questions and request additional information before agreeing to a recommended treatment or procedure.

I understand that this general consent **does not replace separate informed consent forms** that may be required for specific procedures, medications, treatments, or services.

3. RIGHT TO ASK QUESTIONS AND REFUSE TREATMENT

I understand that I may ask questions about my diagnosis, recommended treatment, medications, tests, procedures, alternatives, and expected outcomes.

I understand that I may refuse a recommended treatment or procedure to the extent permitted by law. I understand that refusing recommended care may have health consequences, which my provider may discuss with me.

4. CONSENT FOR LABORATORY AND DIAGNOSTIC SERVICES

I consent to medically appropriate laboratory tests, specimen collection, diagnostic testing, and other examinations ordered by my health-care provider as part of my evaluation or treatment.

I understand that specimens may be sent to an outside laboratory or diagnostic facility when appropriate.

5. CONSENT FOR MEDICATION MANAGEMENT

I consent to the evaluation, prescribing, administration, monitoring, and management of medications when medically appropriate.

I understand that medications may have risks, side effects, drug interactions, contraindications, or other potential complications.

I agree to provide PMG with accurate information regarding my current medications, allergies, supplements, and relevant medical history.

Certain medications or treatments may require additional consent forms or treatment agreements.

6. CONSENT FOR REFERRALS AND COORDINATION OF CARE

I authorize Progressive Medical Group to coordinate my medical care with other health-care providers, specialists, laboratories, pharmacies, hospitals, imaging centers, and other health-care entities as reasonably necessary for my treatment, payment, and health-care operations, consistent with applicable privacy laws.

This consent does not replace a separate HIPAA authorization when one is legally required.

7. CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that Progressive Medical Group may use and disclose my protected health information as permitted or required by applicable law for purposes including:

- **Treatment** – providing, coordinating, or managing my health care;
- **Payment** – billing, obtaining payment, processing insurance claims, and related activities; and
- **Health-care operations** – activities necessary to operate the medical practice, including quality improvement, care coordination, credentialing, compliance, and administrative activities.

HIPAA permits these types of uses and disclosures subject to applicable requirements and limitations.

I understand that this general consent is **not a blanket authorization** for every possible disclosure of my health information. Certain disclosures may require a separate written HIPAA authorization.

8. NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided access to or offered a copy of Progressive Medical Group's **Notice of Privacy Practices**.

The Notice of Privacy Practices explains how PMG may use and disclose my protected health information and describes my privacy rights.

I understand that I may contact Progressive Medical Group with questions regarding its privacy practices.

9. COMMUNICATION

I understand that PMG may contact me using the contact information I provide for purposes related to my health care, appointments, billing, and practice operations, subject to applicable privacy requirements.

Preferred method of communication:

- ☐ Phone
- ☐ Voicemail
- ☐ Text message
- ☐ Email
- ☐ Patient portal
- ☐ Other: _____

I understand that electronic communications may carry privacy or security risks despite reasonable safeguards.

10. TELEHEALTH

When telehealth is offered and appropriate, I understand that telehealth may involve the use of electronic communication and technology to provide health-care services.

I understand that technical problems may occasionally interfere with a telehealth visit and that an in-person visit may be recommended when clinically appropriate.

A separate telehealth consent may be obtained when required by PMG policy or applicable law.

11. FINANCIAL RESPONSIBILITY

I understand that I am responsible for charges associated with services provided to me, including applicable copayments, deductibles, coinsurance, non-covered services, and other amounts for which I am legally responsible.

I understand that insurance coverage is a contract between me and my insurance company. Verification of insurance benefits does not guarantee payment.

I agree to provide accurate insurance and demographic information and to notify PMG of changes.

12. PATIENT RESPONSIBILITY

I agree to provide accurate and complete information regarding my medical history, medications, allergies, symptoms, and other information relevant to my care.

I understand that providing incomplete or inaccurate information may affect my diagnosis and treatment.

I agree to follow reasonable instructions provided by my health-care team and to communicate questions or concerns regarding my care.

13. ACKNOWLEDGMENT

By signing below, I acknowledge that:

- I have read and understand this General Consent for Evaluation and Treatment.
 - I have had an opportunity to ask questions.
 - I understand that I may request additional information about my care.
 - I voluntarily consent to evaluation and treatment by Progressive Medical Group, Inc.
 - I understand that this form does not replace procedure-specific informed consent forms or HIPAA authorizations when those documents are required.
 - I understand that I may withdraw my consent to the extent permitted by law and subject to applicable legal and clinical requirements.
 - I understand that my health information will be handled according to applicable federal and Wisconsin privacy requirements and PMG's Notice of Privacy Practices.
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PATIENT / LEGAL REPRESENTATIVE SIGNATURE

Patient Name: _____

Signature: _____

Date: _____

If signed by a parent, guardian, or legal representative:

Representative Name: _____

Relationship/Authority: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

Staff Name: _____

Date Received: _____

Form Reviewed: ☐ Yes

Notice of Privacy Practices Provided/Offered: ☐ Yes ☐ No

Interpreter Used: ☐ No ☐ Yes

Interpreter Name/ID: _____

Additional Notes: _____

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