Harmony Community Clinic
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General Consent to Evaluation and Treatment

Patient name (print) _____ Date of birth _____ Date _____

1. Consent to care

I voluntarily consent to receive evaluation and care at Harmony Community Clinic. This may include taking my medical history, physical examinations, vital signs, laboratory tests (including blood draws), screening tests, referrals for imaging or specialist care, prescriptions, injections, and other routine services that are appropriate for my condition.

2. Who provides my care

I understand that my care will be provided by Advanced Practice Registered Nurses (APRNs, also called nurse practitioners), nurses, and trained clinical staff, practicing within their scope of practice under Florida law. A nurse practitioner is not a physician. When required by Florida law, nurse practitioners practice under a written protocol with a supervising physician. I may ask about the credentials of anyone involved in my care.

3. Procedures that need separate consent

Some treatments, such as weight-loss medications, IV therapy, injections, peptide therapy, hormone therapy, and aesthetic procedures, have their own specific consent forms. Those forms explain the risks, benefits, and alternatives in more detail and must be signed before treatment.

4. Risks and no guarantees

I understand that even routine care, such as blood draws and injections, carries some risk, including pain, bruising, fainting, infection, and allergic reactions. No guarantee: I understand that medicine is not an exact science. Results vary from person to person, and no promise or guarantee has been made to me about the results of this treatment.

5. Laboratory and outside services

Specimens may be sent to outside laboratories. Outside laboratories, pharmacies, imaging centers, and specialists may bill me separately.

6. Prescriptions and medication history

I authorize Harmony Community Clinic to send prescriptions electronically and to view my prescription history from pharmacies and prescription databases, including the Florida prescription drug monitoring program (E-FORCSE), as required before prescribing certain medications.

7. Not an emergency facility

Harmony Community Clinic is not an emergency room or urgent care center. In a medical emergency I will call 911 or go to the nearest emergency room.

8. My responsibilities

- Give complete and truthful information about my health, medications, and supplements.
- Follow the treatment plan I agree to, or tell my provider if I cannot or choose not to.
- Attend follow-up visits and complete laboratory tests that are ordered for my safety.
- Report side effects or new symptoms promptly.

9. Duration

This consent remains in effect for all visits until I revoke it in writing. Revoking it does not affect care already provided.

I have read and understand this consent to evaluation and treatment. _____ Initials

Signatures

By signing below, I confirm that I have read this form (or had it read to me) in a language I understand, that I had the opportunity to ask questions and all of my questions were answered, and that I agree to its terms voluntarily.

Patient name (print)	Patient signature	Date

Parent / guardian / legal representative (print, if applicable)	Relationship to patient	Representative signature	Date

Provider name and credentials	Provider signature	Date

Tell us about your visit

Your opinion helps other families find quality care. After your visit, scan this code with your phone camera to leave Harmony Community Clinic a review on Google.

Thank you for trusting us with your health.