Mid-Atlantic Nephrology Associates, P.A.

Consent to Treat Policy

Thank you for choosing Mid-Atlantic Nephrology Associates, P.A., for your health care services.

We believe that the physician-patient relationship is strengthened when there is a clear understanding between both parties as to their rights and obligations.

We ask, therefore, that you review and sign the following statement of our Treatment Policy prior to receiving treatment. If you have any questions about our treatment policy, please do not hesitate to ask.

Treatment Policy:

You* consent to and understand the following:

- That the attending physician and physician extenders of Mid-Atlantic Nephrology Associates, P.A. and its clinical and technical employees may administer any treatment or perform any procedures deemed advisable in your care and treatment:
- That you will have the opportunity to discuss proposed procedures and therapeutic courses of treatment with the physician or health professional to your satisfaction;
- That you have the right to consent to or refuse any proposed procedure or therapeutic course of treatment;
- That Mid-Atlantic Nephrology Associates, P.A. will provide the best care possible consistent with the prevailing standards of medical practice, but has made no assurances or guarantees as to the results of treatment.
- That provision of services by the attending physician and physician extenders of Mid-Atlantic Nephrology Associates, P.A. and its clinical and technical employees may be delivered using telemedicine. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I will be responsible for any co-payments or co-insurances that apply to my telemedicine visit.

I have read, understand, and agree to the Treatment Policy described above.

______________________________	______________________________
Patient or Guarantor Name (Print)	Patient or Guarantor Signature
______________________________	______________________________
Witness	Date

**The terms "You" and "your" are used in this document mean the patient's Guarantor.*