# NEW YORK INSTITUTE OF TECHNOLOGY

**ACADEMIC HEALTH CARE CENTER**
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(631) 348-3254 Fax: (631) 348-3031

## Consent for Treatment

I, _____, am the patient or legal guardian, seeking care and treatment by the NEW YORK INSTITUTE OF TECHNOLOGY for the care and treatment of my identified medical conditions. I am aware that the NEW YORK INSTITUTE OF TECHNOLOGY is a teaching entity and that part of the care I receive may be provided with medical residents and medical students in attendance, observing care, and in some cases providing care under the immediate supervision of a physician. I am aware that health care is not an exact science and will be informed of the following:

1. A review of the proposed treatment, including timing, duration, and expected outcome has been explained and, I realize that the outcome in my case will depend on my "body" and my continued care.

2. I understand the importance of correct use of the medications prescribed and will inform my physician of any side affects or the use of other medications, including over the counter medicine(s), I may take.

3. Any additional testing, monitoring, or assessment that this treatment may require, including lab work or other diagnostic studies, will be explained to me, and I understand the ongoing need for care.

4. If the treatment involves any surgical procedure, I will be informed of the procedure; anesthesia involved, and expected recovery limitations and time. I further understand that each procedure, like each patient, is unique and that my specific care may vary based on my unique medical condition.

5. If treatment involves Osteopathic Manipulation, I will be informed of the procedures; the modality involved and anticipated benefit. I understand the response to treatment may vary based on my unique medical condition.

6. I understand that as part of the practice of the Academic Health Centers, my external prescription history may be checked through our electronic medical record system by my treating physician.

I agree to follow the physician's plan for my health care, to the best of my ability. I further agree to ask questions and seek information from my physician and his or her staff, as needed to help in my understanding of my health and medical needs.

If this procedure is considered cosmetic or not covered by my insurance for identified reason, I agree to pay the billed charge in its entirety.

_____ _____

Date Patient/Guardian