University of Nebraska Omaha

Health Services
102 HPER
6001 Dodge Street
Omaha NE 68182
402-554-2374

Informed Consent for Medical Examination and Treatment

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, nurse practitioners, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

2. NO GUARANTEE OF RESULTS: UNO Health Services physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care.

3. I understand that I can change my mind regarding the procedure or treatment. If I do, I must tell the person or the team doing the procedure or treatment *before* they start.

4. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

5. I understand that the clinic, as required by law, must report certain diseases to local and state agencies.

6. I understand that students and others may observe the procedure or treatment for educational purposes. Observers must be approved by this facility.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits). A copy of this document may be utilized the same as the original. I further acknowledge receipt of the Notice of Privacy Practices of UNO Health Services at this visit or at a previous visit.

Patient Information

Printed Name_____ Date of Birth:_____ NUID # _____

Signature: _____ Date: ___/___/____

Parent/Guardian must sign below for patients under the age of 19:

I certify that I have read and understand this document. I authorize University of Nebraska-Omaha Health Services and/or Counseling and Psychological Services (CAPS) to provide medical treatment, mental health and/or substance use treatment to my child:

Name of Minor Child: _____ Minor Child's Date of Birth: Date: ___/___/____

Parent/Guardian Name Printed: _____ Relationship: ☐ Parent ☐ Guardian

Parent/Guardian Signature: _____ Date: ___/___/____