GALEN MEDICAL GROUP, P.C.

CONSENT FOR TREATMENT

If the Patient is under the age of 18, a parent or legal guardian of the Patient must complete and sign this Consent Form.

If the Patient is 18 or older, the Patient must complete and sign this Consent Form.

Patient's Name (*print legibly*): _____ ("Patient")

Patient's Date of Birth: _____

Patient's Age: _____

I, the undersigned, for myself or my minor child who is the Patient, hereby acknowledge that before the Patient may be treated by a Galen Medical Group, P.C. ("Galen") health care provider at the Galen Clinic located at _____ (the "School"), this signed Consent Form must be on file with Galen.

1. I, the undersigned, for myself or my minor child who is the Patient, hereby give consent for any Galen health care provider located at the School premises to evaluate the Patient and provide professional medical services related to diagnosis, medical treatment, and/or counseling as deemed necessary or advisable in the exercise of the Galen provider's professional judgement. Such services may include, but are not limited to, diagnosis and treatment for minor and acute illnesses and injuries, laboratory and diagnostic testing, management and ongoing care for existing medical conditions, and prescribing of medications. While routinely performed without incident, there may be material risks associated with the medical treatment and services provided by Galen.

2. If the Patient is a student at the School and is either: (i) under the age of 18 (a minor), *or* (ii) over the age of 18 and the Patient has provided Galen legal authorization to disclose the Patient's health information to a parent and/or legal guardian:

a. an attempt will be made to contact a parent or legal guardian of the Patient at the time the Patient presents to Galen for treatment. However, certain emergency or other circumstances may not permit Galen the opportunity to contact a parent or legal guardian or Galen's attempt to reach a parent or legal guardian may not be successful,

b. Galen will notify the parent or legal guardian of the Patient regarding health care services received by the Patient, as well as any findings and/or treatment recommendations, and

c. if the circumstances permit, Galen will attempt to contact a parent or legal guardian of the Patient to allow the parent or legal guardian the opportunity to listen to and/or observe the evaluation and treatment rendered to the Patient via teleconference or similar electronic communication means. Such technology cannot be guaranteed as a secure or private form of communication and may lead to unintended disclosures of the Patient's health information.

3. I, the undersigned, for myself or my minor child who is the Patient, understand that:

a. it is my responsibility to relay relevant, pertinent, accurate and complete treatment and medication history about the Patient to Galen,

b. it is my responsibility to update Galen of any changes to the Patient's health condition, immunization records, allergies, or medications that might affect Galen's diagnosis or treatment of the Patient,

c. the practice of medicine is not an exact science and that Galen makes no representations or guarantees regarding the effectiveness or outcome of treatment anticipated by or rendered by a Galen health care provider to the Patient, and

d. in the event I do not understand the purpose or risks associated with any recommended treatment, I will request an explanation and/or clarification to my satisfaction.

4. I, the undersigned, for myself or my minor child who is the Patient, understand that Galen is not affiliated with the School and Galen will not disclose any health information about the Patient to the School without appropriate legal authorization.

5. I, the undersigned, for myself or my minor child who is the Patient, understand that, upon request, I may receive a copy of this Consent Form after I sign it. A photocopy or facsimile of this Consent Form shall be valid and effective, just as the original.

6. I, the undersigned, for myself or my minor child who is the Patient, understand that this Consent will remain valid while I am a student or employee of the School unless revoked by me in writing.

* * * * *

If the Patient is under the age of 18, a parent or legal guardian of the Patient must sign this Consent Form.

If the Patient is 18 or older, the Patient must sign this Consent Form.

Print Name of Person Signing (*print legibly*): _____

Signature: _____

Relationship to Patient (*if Patient is under the age of 18*): _____

Date: _____

Parents and/or Legal Guardians of the Patient to whom heath information may be released and/or discussed and from whom verbal consent may be received (*if Patient under the age of 18*):

Primary Parent/Guardian: _____ (*print legibly*)
Cell Number: _____
Home Number: _____
Work Number: _____

Secondary Parent/Guardian: _____ (*print legibly*)
Cell Number: _____
Home Number: _____
Work Number: _____

Please return to: Galen Medical Group

4976 Alpha Lane, Hixson, TN 37343

or via fax to (866) 396-8865