NANI
Nephrology Associates of Northern Illinois and Indiana

CONSENT FOR CARE AND TREATMENT

Patient Name: _____

Date of Birth: _____

I, _____ , voluntarily authorize and consent to the administration and performance of any or all medical examinations, testing, and treatment considered necessary or advisable by the physicians, mid-level providers (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), nurses, and other healthcare professionals of Nephrology Associates of Northern Illinois and Indiana or NANI. I understand I have the right to revoke this consent, in writing, at any time, except to the extent that Clinicians or Medical Group have acted in reliance of this consent. This consent will remain fully effective until it is revoked in writing.

My signature below indicates that this consent is continuing in nature even after a specified diagnosis has been made and treatment recommended; and I consent to treatment in this office or any other satellite office under common ownership. I understand that I have the right to discuss the treatment plan with my Physician about the purpose and potential risks and benefits of any test ordered for me. If more invasive or interventional testing or procedures are recommended, I understand that I may be asked to read and sign additional consent forms prior to the test(s) and/or procedure(s).

I certify that I have read and fully understand the above statements.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Relation to Patient

_____ _____

Printed Name of Witness | Employee Job Title

_____ _____

Signature of Witness | Date