Bryn Mawr Medical Specialists Association

825 OLD LANCASTER ROAD SUITE 320
BRYN MAWR, PA 19010
610-527-3800

Consent To Treatment / Venue Selection Form

Consent to Medical Care

I hereby present myself for medical care at Bryn Mawr Medical Specialists Association ("BMMSA") and voluntarily consent to receive medical care including evaluation and management, routine diagnostic testing, medical procedures and other treatment by authorized agents/employees of BMMSA.

I acknowledge that no guarantees have been made to me regarding the results of the treatment rendered by BMMSA. As a patient, I understand that I will have access to current and complete information about my condition and will, unless otherwise specified, receive continuity of treatment and receive medical care according to a properly sequenced plan of treatment by one of BMMSA's physicians and/or advance practice providers (APPs).

I acknowledge that before receiving any treatment, I will have an opportunity to ask any questions I may have to the physician and/or APP before I decide whether to give consent for the procedure(s) to be performed and/or treatment rendered. I further acknowledge that all medical procedures and treatment may involve risks, including the risk of an unsuccessful result and/or complications, and that no guarantee has been made as to a result or cure. I have the right, at all times, to be informed of any such risks, as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of not agreeing to the treatment plan. I have the right to consent to or refuse any proposed procedure and/or treatment at any time prior to its performance.

Venue Selection Agreement

NOTICE: **In consideration for all current and future medical treatment provided by BMMSA, any legal claims or civil actions**, including, but not limited to, a claim for medical malpractice in any way related to the evaluation, procedures, treatment and all following medical services provided by BMMSA or its agents/employees, **shall be brought solely in the courts of the county in which care is provided, in the Commonwealth of Pennsylvania**.

If you do **not** agree with the above, you must **initial here** _____ or you will be bound by the above.
Initials

Patient Name (print):_____ **Patient Date of Birth:** _____

Patient Signature: _____ **Date signed**: _____

FOR BMMSA USE ONLY
Patient Account Number: _____