Dr. Alice Wilkenfeld
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Vesta Internal Medicine/Vesta Medical Services Ltd.

Consent to Treat

Effective September 18, 2023

Thank you for choosing Vesta Internal Medicine and Dr. Alice Wilkenfeld for your primary care needs and internal medicine consultation. Dr.Wilkenfeld utilizes the most current and proven methods of evaluating and treating your medical condition(s) in accordance with Evidence-Based Medicine principles.

By signing this form, you grant Dr.Wilkenfeld and Vesta Internal Medicine consent to collect relevant prior medical records such as other doctors' visit notes, laboratory test results, diagnostic radiology reports (such as CT scan, X-ray, MRI etc.), and any other tests related to your condition. Please provide us with this information before your initial visit. Any new data or information should be forwarded to us before your next visit. Furthermore, we are authorized to communicate with any or all of your doctors and other health care providers involved with your care.

As part of our commitment to providing comprehensive and personalized care, the doctor carefully reviews each patient's medical history before their initial appointment. Please note that if the review of your medical records takes more than 30 minutes, there will be a charge for the doctors' time.

We adhere to the privacy regulations outlined by PIPA to safeguard your personal information. Our electronic medical record system is cloud based and encrypted to ensure the security of your sensitive data. Please be aware that our common areas are equipped with audio and visual surveillance for the safety and security of our patients, staff and property. By entering our medical practice, you acknowledge and consent to the presence of audio and video surveillance. Should you have concerns or queries, please contact our office manager for clarification.

Please acknowledge consent below:
I, _____, have read and been offered a copy of the Consent to Treat form. My signature (electronic or on paper) confers my consent for treatment from Vesta Internal Medicine/Vesta Medical Services Ltd., and Dr. Alice Wilkenfeld.

If you wish to authorize the sharing of your medical information with a trusted individual such as a spouse, partner, family member or guardian, please provide their details below.

_____

Name Relationship Phone

Signature _____ Date (m/d/y) _____