Big Apple Cardiology

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Consent for Treatment

General Consent

I voluntarily consent to evaluation, medical treatment, and diagnostic testing provided by Allen Weiss Physician NY, P.L.L.C. d/b/a Big Apple Cardiology and its clinical staff. This consent includes routine medical care, physical examination, diagnostic testing, and other services considered medically appropriate for my evaluation and treatment.

Diagnostic Testing

I understand that my care may include diagnostic testing such as electrocardiograms (ECG), echocardiography, cardiac stress testing, ambulatory rhythm monitoring, vascular ultrasound, sleep apnea testing, or other cardiovascular diagnostic procedures as deemed medically appropriate.

Risks and Benefits

I acknowledge that the practice of medicine and cardiology is not an exact science and that no guarantees or assurances have been made regarding the outcome of my evaluation or treatment. The nature, purpose, potential risks, and expected benefits of recommended tests or treatments may be explained to me and I have the right to ask questions before proceeding.

Medication Use and Adherence

I understand that medications may be prescribed as part of my treatment plan. I agree to take medications as directed and to inform the practice of any side effects, allergic reactions, or concerns regarding my medications. I understand that stopping or changing medications without medical guidance may increase the risk of worsening or untreated medical conditions.

Accuracy of Medical Information

I understand that my healthcare providers rely on the accuracy of the medical history, medication list, allergies, and other information that I provide. I agree to provide complete and accurate information regarding my medical history, medications, supplements, and prior testing to the best of my knowledge. I understand that incomplete or inaccurate information may affect medical decision-making and treatment.

Telehealth and Electronic Communication

I understand that some services may be provided using telehealth or electronic communication technologies when appropriate. I acknowledge that these services may involve electronic transmission of medical information and consent to their use when clinically appropriate.

Refusal of Recommended Testing or Treatment

I understand that my physician may recommend diagnostic testing, procedures, medications, or follow-up care based on my medical condition. If I choose to decline or postpone recommended evaluation or treatment, I acknowledge that this decision may increase my risk of undiagnosed or untreated medical conditions. I understand that I may be asked to sign documentation confirming my decision to decline recommended care.

Diagnostic Test Result Communication

I understand that diagnostic testing (including electrocardiograms, echocardiograms, stress testing, ambulatory rhythm monitoring, vascular ultrasound, sleep apnea testing, laboratory testing, and other cardiovascular imaging) may require follow-up after results are reviewed. I agree to maintain updated contact information with the practice and to follow instructions regarding follow-up appointments or additional testing. If I do not receive communication regarding test results within a reasonable time, I agree to contact the office. I understand that electronic patient portals or secure electronic communication may also be used to provide test results when appropriate.

Urgent Symptoms and Emergency Care

I understand that messages sent through the patient portal, email, or other electronic communication systems are not intended for urgent or emergency medical situations. If I experience urgent symptoms such as chest pain, shortness of breath, fainting, severe dizziness, or other potentially serious medical symptoms, I agree to seek immediate medical

attention by calling 911 or going to the nearest emergency department rather than waiting for a response from the practice.

Consent Validity

This consent applies to the current visit and future visits unless revoked by me in writing.

By signing electronically, I confirm that I have read and understand this Consent for Treatment. My digital signature indicates my authorization for evaluation and treatment by Allen Weiss Physician NY, P.L.L.C. d/b/a Big Apple Cardiology.

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| Electronic Patient Signature (captured digitally) | Timestamp Recorded Automatically |