Instituto Cardiovascular	**CARDIOLOGY OR PRIMARY CARE AT HOME OR OFFICE INFORMED CONSENT**	**VERSION: 01** **CODE: 02** **DATE:05/12/2024**

Date _____/_____/_____

I _____ identified with **CC** ___**TI**___**TE**___ **CE**__ **Passport**___ **Other**___**Nº**_____of_____ **acting on my own behalf or of**_____ identified with **CC**___ **TI**___ **TE**___ **CE**__ **Passport**___**Otro**___**Nº**_____**of** _____ **whose name I am** _____**,** I authorize the Instituto Cardiovascular de Risaralda S.a., to have the **nursing assistant** _____ on its behalf. with **C.C.**_____ **of** _____**, perform** _____ **at** my residence **located in** _____ **city**_____**.**

I hereby acknowledge that it was explained to me that the examination or procedure in question has no known, demonstrable contraindications under normal conditions; however, due to the fact that it is performed at home, any kind of risk is unknown, so taking into account Since the benefits it represents for my concept, compared to the risks of my (or my family member's) displacement, are much greater, I authorize its performance.

I declare that I will follow the instructions mentioned below:

1. Present a copy of the identification document (Civil Registry, Identity Card, Citizenship Card, Immigration Card or Passport), health entity card, medical order and/or authorization.
2. Submit a copy of: medical record, current medication formula and previously performed tests.
3. Have the exact cash corresponding to the value of the moderator fee or value of the private appointment as appropriate. (Our staff does not handle money).
4. Our staff should not suggest, demand or receive any type of tip, much less perform any type of procedure on their own that has not been scheduled and authorized by the company.
5. At least one adult companion who knows perfectly the patient's medical condition (nurse or family member) must be present, who can sign the consent authorizing the procedure.
6. The companion must remain 100% of the time with our official. For no reason should the official be left alone, much less in charge of the patient. If this happens, it is under your responsibility and you exempt both the institution and the official from all responsibility.
7. Please note that the staff assisting in taking the exam, installing the equipment, or performing the primary care procedure is a nursing assistant, **NOT** the physician.

8. The assistant must wear a uniform with a logo and a card that identifies him or her as an official of our institution.
9. At the time of requesting the service, you will be provided with the information of the person who will assist you (Name, ID and security code). This information must be presented before entering your home. If for any reason this protocol is not followed and the official or another person outside the institution enters, it is under your sole responsibility.
10. The assistant who provides the service is not authorized to provide any type of medical information unrelated to his profession. If for any reason this protocol is not followed, it is your responsibility to handle this information.
11. The assistant is not authorized to perform any type of procedure on the patient other than that requested. If for any reason this protocol is breached, the institution is not responsible for any type of adverse event.
12. The assistant is not authorized to manipulate (connect, disconnect, move, etc.) any type of equipment that is available for the management of the patient that is not our property.
13. To take the exam, procedure or installation of the equipment, the companion must be the one who, under the instructions of the assistant, discovers the chest and extremities of the patient and receives instructions to ensure the proper use of the equipment to be installed or the performance of the requested procedure.
14. If for any reason the instructions are not followed, it is the client's responsibility to bear the costs of rescheduling the exam.
15. It is the duty of the companion to check the condition of the equipment at the time of installation since it must be returned in the same conditions. Misuse of the equipment by the patient or his companions that causes demonstrable damage must be assumed by them.
16. The results can be sent by email or can be claimed at any of our offices, during established business hours. (**See opening hours www.Incardiovascular.com)**
17. These results must be presented to your treating doctor who indicated their relevance, so that he or she can define the course of action to follow.
18. This service requires prior scheduling and will only be provided during our business hours.
19. The Institution reserves the right to deny the provision of the service if for any reason it considers that it cannot be provided in an ideal manner, either when it is to be scheduled or at the time of its provision.
20. The Institution reserves the right to deny the provision of the service if for any reason it considers that the displacement may put the integrity of our official at risk.

I have asked the questions that I considered appropriate, all of which have been resolved and with answers that I consider sufficient and acceptable.

Therefore, I consciously and voluntarily give my consent for the _____ to be performed on me, having full knowledge of the conditions and information mentioned above.

_____

Patient Signature

I.D.

_____

Nurse/Nurse Assistant Signature

I.D.

_____

Companion/Resposible Signature

I.D.