Consent for Treatment and Medical Services Form

Please read this document carefully. By signing below, you acknowledge your understanding and give consent for medical treatment and services.

1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Home Address:

Emergency Contact Name:

Emergency Contact Phone:

2. Consent for Medical Treatment

I hereby authorize the medical providers, clinical staff, and designated assistants to administer such medical treatments, diagnostic procedures, laboratory tests, and physical examinations as deemed necessary for my care and well-being.

I understand that medical treatment is not an exact science and that no guarantees have been made to me regarding the results of any examination, treatment, or procedure.

3. Financial Responsibility

I acknowledge that I am financially responsible for all charges associated with the services rendered. I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits directly to the healthcare provider.

4. Privacy and HIPAA Acknowledgement

I acknowledge that I have been provided access to the Notice of Privacy Practices, which details how my personal health information (PHI) may be used and disclosed under federal law.

5. Authorization and Signatures

By filling in the fields below, I certify that I have read this form, understand its contents, and voluntarily agree to the terms of this Consent for Treatment.

Printed Name of Patient or Legal Representative:

Relationship to Patient (if signed by Representative):

Date (MM/DD/YYYY):

Witness Name:

Witness Date (MM/DD/YYYY):