General Medical Consent and Financial Responsibility Form

Please read this document carefully. This form must be completed, signed, and dated prior to receiving medical treatment.

1. Patient Information

Full Name:

Date of Birth: MM/DD/YYYY

Phone Number:

Email Address:

Street Address:

City, State, Zip:

2. Emergency Contact Information

Contact Name:

Relationship to Patient:

Contact Phone Number:

3. General Consent for Medical Treatment

I hereby authorize the medical staff, physicians, and clinicians to perform diagnostic procedures, administer treatments, and provide medical care that is deemed necessary for my health and well-being. I understand that medicine is not an exact science and that no guarantees have been made to me regarding the results of examinations or treatments.

Please write "I CONSENT" to agree:

4. Financial Responsibility and Assignment of Benefits

I understand and agree that I am financially responsible for all charges associated with my medical care, regardless of my insurance coverage. I authorize the release of any medical information necessary to process insurance claims. I also authorize direct payment of medical benefits to the healthcare provider for services rendered.

If my insurance provider denies payment or covers only a portion of the fees, I acknowledge that I am responsible for the remaining balance, including co-pays, deductibles, and non-covered services.

Please write "I AGREE" to accept financial responsibility:

5. Acknowledgement and Signature

By signing below, I certify that I have read, understood, and agree to the terms of this General Medical Consent and Financial Responsibility Form.

Printed Name of Patient or Legal Representative:

Signature of Patient or Legal Representative:

Relationship to Patient (if signed by Representative):

Date Signed: MM/DD/YYYY