Patient Consent and Signature Declaration

Please read the following declarations carefully. This document must be completed, signed, and printed for your medical record.

1. Consent to Treatment

I hereby consent to the administration and performance of all medical treatments, diagnostic procedures, and administrations of medication that may be considered necessary or advisable by my attending physician or healthcare team.

2. Release of Information

I authorize the release of any medical or other information necessary to process my insurance claims. I also authorize the release of medical information to other healthcare providers involved in my care for continuation of treatment.

3. Financial Responsibility

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

4. Acknowledgement of Privacy Practices

I acknowledge that I have been provided access to the Notice of Privacy Practices, which details how my protected health information may be used and disclosed.

5. Declaration and Signature

By filling out and signing the fields below, I certify that I have read, understood, and agree to all the terms and conditions outlined in this consent document.

Patient Full Name (Printed):

Patient Date of Birth (MM/DD/YYYY):

Authorized Representative Name (If applicable):

Relationship to Patient (If applicable):

Signature (Write 'SIGNED' or sign physically after printing):

Date Signed (MM/DD/YYYY):

Witness Name (Printed):

Witness Signature: