Consent for Treatment

Treatment: I the patient/parent legal guardian, with my signature, authorize this Practice and any employee/staff working under the direction of the physician , to provide medical care me, or to this patient for which I am the legal guardian, or for which I am the legal ability to provide consent. This medical care may include, but shall not be limited to, preventative, diagnostic, therapeutic, rehabilitative, counseling, assessment or review of physical or mental status/function of the body, and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent encompasses contact and discussion with other health care professionals for health care and treatment, and use of my demographic information for health care operational and billing purposes.

Payment: In consideration of any medical care provided to the patient, I assign to Practice and providers associated with Practice all my rights, title and interest to any and all medical reimbursement under my insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by the practice.

I agree that all telephone numbers and email addresses I provide as contact information to Practice may be used by the practice and those acting on its behalf to communicate with me by telephone (including cell phone), text, or any automated or prerecorded messages, for all treatment, payment and operational purposes.

Expiration: Your authorization is valid for one (1) year.

Patient Name (PLEASE PRINT FIRST & LAST NAME):____

Parent/Legal Guardian SIGNATURE:____

Relationship to Patient:____

Date:__________________________