

Consent to Treat Form

1. I give permission for **THE CLINIC** to give me medical treatment.
2. I allow **THE CLINIC** to file for insurance benefits to pay for the care I receive.

I understand that:

- **THE CLINIC** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient's Signature

Date

Parent or Guardian Signature
(for children under 18)

Date

Print name