Family Health Primary Care

General Consent for Treatment

Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Consent for Treatment

I hereby consent to and authorize the providers at Family Health Primary Care to provide medical care and treatment deemed necessary for my health. This may include, but is not limited to: physical examinations, diagnostic tests and laboratory services, administration of medications and injections, and minor procedures and treatments. I understand that this consent is valid for all routine healthcare services provided by the clinic and does not apply to specialized procedures that may require separate written consent.

Consent for Use and Disclosure of Health Information

I acknowledge that my medical information may be used or disclosed for purposes of treatment (coordinating or managing my healthcare), payment (billing insurance or myself directly), and healthcare operations (quality improvement, compliance, administrative activities). I have been offered a copy of the Notice of Privacy Practices that describes how my medical information may be used and disclosed.

Financial Responsibility

I understand that I am financially responsible for all charges for services rendered, including those not covered by my insurance. I agree to provide accurate insurance information and notify the clinic of any changes.

Assignment of Benefits

I authorize payment of medical benefits directly to Family Health Primary Care for services rendered.

Patient Rights

I understand that I have the right to refuse treatment to the extent permitted by law; request restrictions on how my health information is used or disclosed; and revoke this consent at any time in writing, except to the extent that action has already been taken.

Acknowledgment & Signature

Patient/Guardian Name (Print): _____

Signature: _____

Date: _____