**Consent to Treat Form**

1. I (patient name) give permission for **[practice name]** to give me medical treatment.
2. I allow **[practice name]** to file for insurance benefits to pay for the care I receive.

I understand that:

* **[practice name]** 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.

1. 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 Date

(for children under 18)

Print name