

FCMH and FCMH Medical Clinics

CONSENT TO TREATMENT

Patient Name _____ Date of Birth _____

I consent to the care provided by the health care professionals associated with FCMH and FCMH Medical Clinics, including diagnostic procedures, examinations, medical and minor surgical treatment, or clinical services recommended by such professionals, and performed by them, their assistants, or other designees.

I understand that this Consent to Treatment will be valid and remain in effect, unless and until revoked, in writing. I have reviewed this Consent to Treatment, understand its contents, and have had an opportunity to ask any questions I might have. I voluntarily sign below.

FINANCIAL AGREEMENT: I agree to be financially responsible and pay for the services rendered to the patient in accordance with the regular rates and terms of FCMH and FCMH Medical Clinics.

TREATMENT OF MINOR: If the above-named patient is a minor, my signature below as the parent/guardian of the minor authorizes FCMH and FCMH Medical Clinics to provide medical/dental/vision and/or emergency treatment to the patient. I understand that this authorization is given in advance of any specific diagnosis or treatment. My signature below is intended to provide ongoing consent to treatment and I intend this Consent to Treatment to be in force when the patient is accompanied to FCMH and FCMH Medical Clinics by family members (grandparents, aunts/uncles, cousins, adult sibling) and the following designated unrelated adults.

Signature Relationship to Patient Date