General Consent for Medical Evaluation and Care

Please review and complete this form to provide your consent for evaluation, treatment, diagnostics, and related communication at our clinic.

Patient Information

Please provide your personal details below.

Full Name *

Date of Birth (MM/DD/YYYY) *

Phone Number *

Email Address

Address

Consent for Evaluation & Treatment

Consent to medical evaluation and treatment.

I consent to receive evaluation and treatment as deemed necessary by the clinic's healthcare providers. *

☐ I agree and consent to evaluation and treatment.

Diagnostic & Ancillary Services Consent

Consent to diagnostic procedures and ancillary services.

I consent to the performance of diagnostic tests and ancillary services (such as laboratory tests, imaging, etc.) as recommended by my provider. *

☐ I agree and consent to diagnostic and ancillary services.

Medication & Allergy Disclosure

Please provide information about your current medications and allergies.

Are you currently taking any medications? *

◯ Yes
◯ No

If yes, please list your current medications.

Do you have any allergies? *

◯ Yes
◯ No

If yes, please list your allergies.

Consent for Communication

Consent to be contacted by the clinic.

I consent to be contacted by the clinic via phone, email, or text message for appointment

reminders and healthcare communications. *

☐ I agree to receive communications from the clinic.

Telehealth Consent

Consent to the use of telehealth services, if applicable.

I consent to receive healthcare services via telehealth (video or phone consultations) if deemed appropriate by my provider. *

☐ I agree to telehealth services if needed.

Financial Responsibility

Acknowledgment of financial responsibility for services rendered.

I understand and accept responsibility for payment of all services rendered, including those not covered by my insurance. *

☐ I accept financial responsibility for services received.

Release of Information

Consent to the release of medical information as required.

I authorize the release of my medical information as required for treatment, payment, and healthcare operations, in accordance with privacy regulations. *

☐ I authorize the release of my medical information as described above.

Risks & Acknowledgments

Please acknowledge the potential risks and your understanding.

I understand that medical evaluation and treatment may involve risks and that no guarantees can be made regarding outcomes. *

☐ I acknowledge the risks and have had the opportunity to ask questions.

Patient Rights (Informational)

Your rights as a patient at this clinic.

You have the right to be informed about your care, to ask questions, and to refuse treatment to the extent permitted by

law. Your privacy and confidentiality will be protected in accordance with applicable regulations. For more information, please ask our staff.

Consent Confirmation

Please confirm your understanding and agreement.

By submitting this form, I confirm that I have read, understood, and agree to the above consents and acknowledgments. *

☐ I confirm my understanding and agreement to all sections above.