Consent to Treat

I _____ give permission for **Prime Immediate and Primary Care** to give me medical treatment.

I allow **Prime Immediate and Primary Care** to file for insurance benefits to pay for the care I receive.

I understand that:

- **Prime Immediate and Primary Care** 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.

I understand:

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

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's Signature	Date
Parent or Guardian Signature	Date
(for children under 18)	
Print name	Date

Submit