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.

_________________________________ ______________

Patient's Signature Date

_________________________________ ______________

Parent or Guardian Signature Date

(for children under 18)

_________________________________ ______________

Print name Date