



## Consent to Treat

Updated 4/27/2023

1. I \_\_\_\_\_ give permission to Hope & Help to provide me with health services and medical treatment. This includes medical diagnosis and treatment using appropriate procedures, laboratory sampling, and pharmaceutical interventions.
  
2. I allow Hope & Help to file for insurance and/or grant benefits to pay for the care I receive.
  
3. Financially I understand that:
  - a. Hope & Help may have to send my medical record information to my insurance provider.
  - b. I will maintain responsibility for my share of the costs, if applicable.
  - c. I must pay for the cost of these services if my insurance does not pay or I do not have insurance or grant benefits.
  - d. I agree to aid and or assist in necessary processes to complete any billing claims.
  
4. Procedurally I understand that:
  - a. I have the right to refuse any procedure or treatment and must disclose this clearly to my provider at the time of service or before.
  - b. I have the right to discuss all medical treatments with my clinician.
  - c. I will discuss any questions/concerns with my provider at the time of my service.
  - d. I will maintain and safeguard my access to the patient portal as my responsibility.
  - e. Cancellation of appointments must be 24-hours in advance, or I will be charged.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature (if 17 or under)

\_\_\_\_\_  
Date