General Consent to Treatment

I, _____, grant permission to MyCare Health Center and its medical personnel to provide me
Patient Name
with any medical care they may deem reasonably necessary for my health and well-being.

I understand that treatment at MyCare Health Center involves a team approach, and I understand my care may be discussed with medical personnel involved in my care.

I understand MyCare Health Center will bill my insurance plan for medical services, and understand certain care may not be covered or billable to my insurance plan. If this is the case I agree I am responsible for all medical services provided which are not covered by my insurance plan, which includes co-payments, deductibles, and co-insurance charges.

I understand that unless other arrangements are made prior to receiving medical services, payment is expected at the time of service.

I understand MyCare Health Center may request information from insurance companies as needed to receive payment.

By consenting to treatment I acknowledge and understand that at no time have I been provided with any guarantee as to the specific outcomes of medical services.

By consenting to treatment, I acknowledge my willingness to accept known risks and complications, no matter how slight the probability of occurrence.

I understand that it is very important that I provide the MyCare medical personnel with accurate personal and health information before, during, and after treatment.

I understand it is important for me to follow MyCare Health Center's medical personnel's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other physicians or specialists, and return for scheduled appointments.

I understand if I fail to follow the advice of MyCare medical personnel, I may increase the chances of a poor outcome.

By signing this Consent, you (or your legal representative) understands and agrees to the above statements. This consent is effective today until rescinded or changed by me, in writing.

IF THE PATIENT IS AN ADULT

I hereby consent to treatment at MyCare Health Center.

_____ _____
Patient signature Date

IF THE PATIENT IS LESS THAN 18 YEARS OF AGE OR NOT LEGALLY COMPETENT

I, _____, on behalf of the patient consent to treatment at MyCare Health Center.
Name of Parent / Legal Representative

Signature _____ _____
Date

Relationship to Patient _____

IF THE PATIENT IS UTILIZING TELEHEALTH SERVICES

I, _____, have reviewed the information above and have received verbal consent to treat.
Name of Staff / Provider

Signature _____ _____
Date