CONSENT FOR TREATMENT & HIPAA ACKNOWLEDGMENT FORM

SECTION 1 – PATIENT INFORMATION
Name: _____ DOB: ____ / ____ / _____
Address: _____
Phone: (___) ___■____ Email: _____

SECTION 2 – GENERAL CONSENT FOR TREATMENT
I voluntarily consent to routine physical exams, diagnostic procedures, laboratory testing, imaging, injections

SECTION 3 – TELEHEALTH SERVICES (if applicable)
■ I consent to receive medical services via telecommunication technologies. Risks, benefits, and alternative

SECTION 4 – FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS
I authorize direct payment of insurance benefits to the clinic. I accept responsibility for charges not covered b

SECTION 5 – RELEASE OF INFORMATION & HIPAA NOTICE
I acknowledge receipt of the clinic's Notice of Privacy Practices. I authorize the clinic to release information r

SECTION 6 – ELECTRONIC COMMUNICATION AUTHORIZATION
■ Email ■ SMS ■ Patient portal messaging
I understand that unencrypted communication may carry confidentiality risks.

SECTION 7 – PHOTOGRAPHY / VIDEO
■ I authorize ■ I decline
clinical photographs or videos for: ■ Treatment ■ Medical record ■ Teaching

SECTION 8 – MINOR■SPECIFIC CONSENT (if patient <18)
Parent/Guardian Name: _____ Relationship: _____
■ I give permission for the minor patient named above to receive treatment.

SECTION 9 – SIGNATURE
By signing, I confirm I have read, understood, and agree to all sections of this form.

Signature _____ Print Name _____ Date ____/____/_____ Time
Witness (staff): _____ Date ____/____/_____