

## 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 alternatives

### SECTION 4 – FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS

I authorize direct payment of insurance benefits to the clinic. I accept responsibility for charges not covered by

### 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 to

### 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_