Improving Lives, Improving Care

Patient Name: ____

CONSENT TO TREATMENT

1. I hereby voluntarily consent to care at and by Affinity Health Group (“Affinity”), which may encompass certain routine out-patient procedures and certain diagnostic procedures, examinations and medical treatment including but not limited to routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribed by the provider.
2. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by Affinity and its providers as is necessary in the medical staff’s judgment.
3. If attached, I have reviewed and understand the supplemental information provided by my physician regarding specific treatment and/or procedures that may be provided.
4. I consent to receive all electronic communications from Affinity, including but not limited to phone calls, emails, text messages, etc. If at any time I no longer want to receive appointment reminders, I will advise Affinity in writing (email or letter), and Affinity will discontinue that service.
5. I understand that Affinity consists of primary care, specialty, and other ancillary healthcare providers. Affinity also includes an industrial medicine clinic. Affinity maintains its records electronically. This allows my medical information to be available throughout Affinity.
6. Affinity asks that you give 24-hour notice if you will not be able to keep your scheduled appointment. I understand that I must notify Affinity at least 24 hours prior to my scheduled appointment if I willnot be able to keep my appointment. I also understand that if I have numerous ‘no shows’ I may be subject to dismissal from my providers practice due to patient noncompliance.
7. I hereby authorize my insurance carrier(s) to pay Affinity, all benefits due me, if any, by reason of service described in the statements rendered and as provided for by the policy contract with my insurance carrier(s).
8. I understand that this Consent Form will be valid and remain in effect as long as I (he/she) attend any Affinity clinic.
9. This form has been explained to me, along with any attachment, and I understand their contents.

______________________________ ______________________

Signature of Patient or
Person Authorized to Consent for Patient — Date

If patient is a minor or is unable to consent, ______________________________________
Patient Name

A. Patient is a minor_________years of age.

Name of legal Guardian ________________________________

B. Patient is unable to consent because ____

____ ______________________

Signature of Person Authorized to Consent for Patient — Relationship

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***REQUIRED* RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of medical information necessary to process my claim. As a courtesy to Affinity’s patients, we will file the claim with your insurance carrier with the understanding that if your insurance company does not pay, you are responsible for payment of this account.

Patient (or Guardian):____Date___________
Print — Sign

~~Rev'd 3/2/2022~~