



Patient Name: _____

CONSENT TO TREATMENT

- 1. I hereby voluntarily consent to care at and by Affinity Health Group, which may encompass certain routine ENT procedures such as (but not limited to) nasal endoscopy, cerumen removal, mastoid debridement, fiber optic laryngoscopy, and tubes and certain other 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 Health Group and its providers as is necessary in the medical staff's judgment.
- 3. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend any Affinity Health Group clinic.
- 4. I hereby authorize my insurance carrier(s) to pay Affinity Health Group, all benefits due me, if any, by reason of service described in the statements rendered and as provided for the policy contract with my insurance carrier(s).
- 5. This form has been explained to me and I understand its 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

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

I authorize the release of medical information necessary to process my claim. As a courtesy to our patients we will file the claim with their insurance carrier with the understanding that the patient/guardian, not his/her insurance company is responsible for payment of this account.

Patient (or Guardian): _____ Date _____
Print Sign