ODAM MEDICAL GROUP
Family Care & Chronic Diseases

Consent to Treat Form

1. I _____ (patient name) give permission for **Odam Medical Group** to give me medical treatment which may also include all due vaccinations.

2. I allow **Odam Medical Group** to file for insurance benefits to pay for the care I receive.
   - I understand that:
   - **Odam Medical Group** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay.
   - If you do not have insurance, you will not be billed.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

PLEASE COMPLETE THE FOLLOWING

First Name_____Middle Name_____Last name_____

Date of Birth_____ Phone Number_____ Gender_____

Ethnicity_____ Race_____

Address_____City_____State_____

Zip Code_____

Insurance_____**Group Number**_____**ID Number**_____

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date

(For children under 18)

_____

Parent or Guardian Print Name