General Consent For Treatment

Patient Name:
Date of Birth:
Address:

I consent to have treatment or physical examination / testing performed by the physician, nurse practitioner and/or professional staff at . I permit the physician, nurse practitioner, this facility, and its employees and all other persons caring for me to treat me in ways they judge are beneficial to me, or have been requested by my employer or prospective employer. I understand that this care may include tests, examinations, x-rays, and the drawing of my blood.

If You Intend To File A Claim for A Work-Related Injury

If you are claiming a work-related injury, you MUST PROMPTLY notify your employer of this injury and provide the necessary information for your employer to file a workers' compensation claim for the accident. A claim must be filed and approved in order for medical benefits to be paid. If your injury is ruled NOT work-related, or you fail to follow the required procedures for making a claim, you will be responsible for the payment of your bill for all medical services provided.

I have read this payment policy and understand it. My questions have been answered to my satisfaction.

Signature: Date: