Sunrise Family Clinic

Consent to Treatment

Patient Name: _____ Patient Date of Birth: _____ Best Phone: _____

Alternate Phone: _____ E-mail **(required)**: _____

I, the undersigned, recognize the following information related to my treatment at Sunrise Family Clinic (SFC).

A. I have received a copy of patient rights and responsibilities. I recognize that I have the responsibility, in particular, to:

- Actively work with my provider to solve problems and to develop goals.
- To discuss my treatment plan, ask questions when I don't understand, and make changes when needed.
- Take medications as prescribed by my provider or discuss why I think I will not be able to take the medication.
- Notify my provider of any changes in my medications or if additional medications have been prescribed for me.
- Seek additional help for any mental health, alcohol or drug problems.
- Treat Sunrise Family Clinic staff and other patients with respect.

B. I understand and agree that SFC may use and disclose my heath information in the manner described in SFC's Notice Privacy Practices. In signing this form, I acknowledge that I have received the opportunity to read and review SFC's Notify of Privacy Practices and had any questions regarding it answered.

C. I authorize SFC or SFC's designee to disclose to payors including, but not limited to, insurers, the Centers for Medicare and Medicaid Services, or any other parties that may be liable for all or part of the SFC charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to SFC. I also authorize SFC to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my provider or SFC, as may be necessary. I understand that SFC will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or clinic operations.

D. Opt out:

Please check if you DO NOT WANT SFC staff to leave detailed messages (such as lab results):

□ **No, do not leave messages**

E. Can SFC staff discuss your care with anyone other than yourself? □ **Yes** □ **No**

Please list names: _____ _____

_____ _____ **Initials: _____**

I understand that I have the right to refuse to sign this consent. If I refuse to sign this consent or if I revoke this consent in the future I understand that SFC will not provide any treatment to me or arrange for treatment on my behalf, except under certain emergencies or if otherwise required by law. I understand that this consent will remain in effect until I provide notice that I would like this consent to be discontinued or revoked.

I hereby give my voluntary informed consent to treatment, including diagnostic procedures, surgical and medical treatment as discussed with my provider, at Sunrise Family Clinic. I also understand that I will be billed for services provided, including no show fees and late charges according to the financial policy. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care. If I should leave SFC against medical advice or prior to treatment being completed, I hereby relieve provider and SFC of all liability for my action. I give my voluntary consent for SFC to access my pharmacy and immunization records electronically, to better care for me and prevent medication interactions. I also consent to calls and texts from SFC's automated systems. Please notify us in writing if you DO NOT WANT our automated system to text or call to remind you about appointments and lab results. You may choose the method of contact via your patient portal.

Please let us know if you otherwise have any questions.

_____ _____

CLIENT SIGNATURE DATE