Patient Consent for Care and Treatment

I have fully read, fully understand, and fully accept the following policies of **Acute Family Medicine Clinic, Inc**

Insurance and Payment Policy
Appointment, Walk-In, No Show, and Cancellation Policy
Cell Phone Policy
Confidentiality and Privacy Policy
Lab, X-ray, Pathology, and Test Results Policy
Life Threatening Emergency Policy
Pain Policy
Photo Identification Policy
Treatment of Minors Policy

I, the undersigned, do hereby give my consent for **Acute Family Medicine Clinic, Inc** to furnish medical care and treatment to _____(Print patient name) that is considered necessary and proper in diagnosing or treating a physical and/or mental condition.

_____

Print Patient's Name

_____ _____

Print Name of Patient or Legal Guardian, if applicable **Relationship to Patient**

_____ _____

Signature of Patient or legal Guardian **Date**