Consent to Treat

I hereby give Bay Clinic, Inc., consent to obtain historical information, perform physical examinations, order diagnostic tests and give such treatment as the providers deem appropriate for my medical, dental, and/or mental health. I understand that this is for, but not limited to, obtaining medical, dental, and social/psychiatric histories, performance of physical examinations, repair or minor cuts, tuberculin skins tests, injection of local anesthetics, and medication (such as insulin, epinephrine, etc.), injection of immunizations, and all other ordinary medical/dental office procedures.

I understand that for surgery and/or other procedures not covered above, I will be informed and provided with additional verbal and/or printed information regarding the additional treatment. I further understand that no treatment will be given to me without a signed consent by me for the procedures that do not fall within the scope of ordinary medical and/or dental office procedures’ stated above.

In cases of emergency I hereby give permission for the rendering of all such medical and dental services deemed necessary to stabilize my condition if I am physically or mentally impaired and an adult family member is not readily available. I release Bay Clinic, Inc. from liability that may arise as the result of such treatment, unless due to sole negligence of its staff.

I understand that Bay Clinic, Inc. is committed to offering superior quality of care to all patients regardless of race, ethnicity, religion, sex, age, or handicap status.

My signature certifies that I am of legal age (18 years of age or older) or am an emancipated minor by the definition of State Laws.

I understand I am not consenting to any experimental procedures or to any tests solely for the purpose of research or scientific study. My photograph may be used for medical and dental records purpose only.

I authorize release of information to all third party payors, health, dental, and social services agencies, as well as Medicare and authorize Bay Clinic, Inc. to bill my charges to Medicare. I understand that I am responsible for my medical and dental expenses regardless of my health and dental insurance status.

I understand that I must provide written documentation to support my income level and health and dental insurance information; and if I do not provide documentation, or if I falsify information, Bay Clinic, Inc. may terminate my health and dental care services.

Consent to Treat Acknowledgment

I certify that I have read ALL the above (or had the information read to me) and fully understand the information provided to me.

_________________________________________  ______________________________________
Patient Name (Print)  Parent/Guardian Name (Print)

_________________________________________
Patient Signature or Parent/Guardian Signature

______________________________  ____________________________  ____________________________
Staff Witness (Print)  Staff Witness Signature  Date

Revised 5/23/18 MH