RejoiceMD

Consent for Diagnosis & Treatment

I acknowledge that I am voluntarily giving my permission to the authorities of RejoiceMD and the Provider in charge, as they may deem necessary, to provide medical services to me.

This may include discussion of tentative diagnoses, methods and modalities to be used in treatment, and possible outcomes. I understand that as part of this process, I may be recommended to receive diagnostic testing, procedures, and/or medications as appropriate. I understand that treatment outcomes cannot be guaranteed, and that treatment can at times be uncomfortable or difficult. I understand that I have the ability to decline any recommended services at any time, but this may affect my treatment process and outcome.

I understand that the clinic does not provide 24-hour coverage for my medical needs. In case of an urgent or life-threatening situation, I will call 911 or go to the nearest emergency room.

I also understand that refusal to comply with the Provider's recommendations could result in the termination of the patient-provider relationship. I also understand that I have the right to terminate the relationship at any time.

I further acknowledge that I have read and understand the Policies and Procedures of RejoiceMD, including the limits of confidentiality regarding treatment, and the office policies regarding scheduling, emergency coverage, fees and billing, insurance filing, missed appointments, court appearances, copying records, prescription refills, phone consultations, and other related matters. I acknowledge my understanding of and willingness to abide by these policies and procedures by my signature below.

Patient Name: _____

Date of Birth: _____

Patient/Guardian Signature: _____

Date: _____

Relationship to Patient (if applicable): _____