

Consent to Treat

I acknowledge that I have reviewed and agree to the following:

- □ I accept the payment policy
- □ I accept the medicare benefit policy (if individual is > or = 65 years old)
- □ I accept the cancellation/no show policy
- □ I accept HIPAA/Privacy Rights

Name (Printed):_____

Name (Signed):_____

Date:____/___/____