CONSENT FOR TREATMENT

This consent will be effective after the date it is signed at *Seegott Health LLC, dba TruCare.*

Consent for Treatment/Care

As patient/parent/authorized representative, I hereby voluntarily give my consent to the rendering of such care including diagnostic procedure, medical and surgical procedure and treatment as prescribed by a duly licensed physician, healthcare facility or their authorized designees, as may in their professional judgment be necessary to provide for the medical, surgical or emergency care.

I have accurately completed the Medical History intake information form, identified all the medical/physical conditions, medications I/patient is taking (including over-the-counter), and known allergies.

I understand that *Seegott Health LLC, dba TruCare* depends on information I have provided, and any discrepancies may complicate the treatment, cause injury and/or reduce my chances of successful treatment outcome. If there is any change in any of my medical history, I agree to provide all updated information.

I acknowledge that no guarantee has been made to me as to the effect of such examinations or treatment.

Financial Responsibility

I understand and agree that I assume financial responsibility to all charges for medical and related professional services performed or by a physician and/or healthcare facility. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges.

I understand my signature constitutes my acknowledgement that:

1. I have read and agreed to the foregoing;
2. The diagnostic procedures and/or treatment have been adequately explained to me by the health professional and that I have received all information I desire concerning the same;
3. That I authorize the consent to the diagnostic procedures and/or treatment; and
4. I am releasing the healthcare facility from liability.

I understand that I may withdraw this consent in writing. My withdrawal will not be effective for actions already taken, or in progress.

I have read this form, received a copy, and I am the patient or authorized to act on behalf of the patient.

PATIENT SIGNATURE: _____
PRINTED NAME: _____
DATE & TIME: _____
RELATIONSHIP, if not patient: _____

WITNESS: _____ DATE: _____TIME: _____