Desert Star
FAMILY PLANNING

Consent for General Medical Treatment

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I agree to see the providers at Desert Star Family Planning for the diagnosis, evaluation, and management of my medical problems. I agree to advise my provider of the medications I am taking, of other providers I might be seeing for medical care, and of sensitivities and allergies to medications. I understand that the information I will provide is true, accurate, and complete and that my healthcare choices will depend on that information.

I consent to providing history to my provider and to their recording of that in my chart. I consent to physical examination required for diagnosis and evaluation. I consent to the prescribing of medications or surgery or devices for the appropriate treatment of my disorders. I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I recognize that if a specific treatment involves surgical care for a problem that I have, I have the right to a separate informed consent for the procedure which will specifically cover the risks, benefits, and alternatives to that treatment. I further understand that there is no express or implied guarantee of the outcome of the treatments offered by my provider(s) here, the practice of medicine is based on science but is influenced by many factors beyond the control of the provider.

This consent form will be signed by parents or guardians for the care of minor children or persons for whom the courts have appointed a legal guardian.

I can revoke this authorization at any time by simply asking that my records, or copies thereof, be transferred to a provider of my choice. Revocation of the consent to treatment does release the providers in this office from responsibility to treat me. Other reasons for which my provider can release me from the practice are outlined in the practice policies.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I agree to be responsible for any balance due to Desert Star Family Planning for any professional services or supplies provided to me by any provider in this office. I will work with them to coordinate benefits with any insurance plans I may have, but the ultimate responsibility for the services provided is mine.

Patient Name (Print)	Date of Birth (MM/DD/YYYY)
Patient Signature	Date Signed
Signature of Parent or Legal Guardian, if applicable:	Date Signed
Witness	Date