HOPE&HELP®

4122 Metric Drive, #800
Winter Park, Florida 32792

P: 407.645.2577
F: 1.888.905.2634

www.hopeandhelp.org

CONSENT TO TREAT

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1. I _____ give permission to Hope & Help to provide me with health services and medical treatment. This includes medical diagnosis and treatment using appropriate procedures, laboratory sampling and pharmaceutical interventions.

2. I allow Hope & Help to file for insurance and or grant benefits to pay for the care I receive.

3. Financially, I understand that:
   - Hope & Help may have to send my medical record information to my insurance provider.
   - I will maintain responsibility for my share of the costs, if applicable.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance or grant benefits.
   - I agree to aid and or assist in necessary processes to complete any billing claims.

4. Procedurally, I understand:
   - I have the right to refuse any procedure or treatment and must disclose this clearly to my provider at the time of service or before.
   - I have the right to discuss all medical treatments with my clinician.
   - I will discuss any questions or concerns with my provider at the time of my service.
   - I will maintain and safeguard my access to the patient portal as my responsibility.
   - Cancellation of appointments must be 24-hours in advance, or I will be charged.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature Date

(Required for patients 17 and younger)