HOPE&HELP
HIV/STI Prevention, Testing, & Treatment Services

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CONSENT TO TREAT

UPDATED: 2/24/2020

1. I _____ give permission for 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 company.
   - 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's Signature Date

_____ _____
Parent or Guardian Signature Date
(for minors under 18 years old)