Texas Family Clinic

Consent to Treat Form

1. I _____ (patient name/parent or guardian) give permission for **Texas Family Clinic** to give me medical treatment.

2. I allow **Texas Family Clinic** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **Texas Family Clinic** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date
(for children under 18)

_____ _____

Print name

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