Teche HEALTH Patient Name: _____

Teche Health staff should complete below if Acknowledgement & rights and Responsibilities Section is not signed.

Did the patient receive the Privacy Notice? ☐ YES ☐ NO Employee Initials: _____

DOB: _____

Integrated Health Care Consent to Treatment

Before you give your consent, be sure you understand the information given below. We will be happy to answer any questions you have. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary for my understanding of the written or spoken information given during my healthcare visits. **Consent for Treatment:** I request Teche Health to provide **me (or my minor dependents)** with medical, dental, behavioral health (substance abuse, psychological, or psychiatric), and/or social care. I will be given information about the test(s), treatment(s), procedure(s), and medication(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I hereby request that a person authorized by Teche Health provide appropriate evaluation, testing, and treatment. As possible and practical, I will cooperate fully with the provider, adhering to the treatment regimen and screening procedures set forth.

It is agreed that the practice of medicine is not an exact science. No guarantee can be made, real or implied, as to the result of services.

Right to Withdraw Consent: I have the right to withdraw my consent for treatment of myself and/or my child(ren) at any time by providing a written request to the treating provider.

Expiration to Consent: This consent will expire one year after the signature date, unless otherwise specified.

Patient/Legal Guardian's Initials: _____ Date: _____