HARVARD
Family Physicians, P.C.

Family Medicine OB/GYN Pediatrics Pharmacy

CONSENT TO TREATMENT

Please read the following information below. Your signature below applies to the service rendered in conjunction with all of your visits at Harvard Family Physicians.

CONSENT TO TREATMENT: I, the undersigned, consent to outpatient care at Harvard Family Physicians, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to: routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribed by the provider. I further consent to the performance of those diagnostic procedures, examinations and referring of medical treatment by the medical staff including physicians, nurse practitioners, physician's assistants, medical assistants or their designees as is necessary in the medical staff's judgment. I authorize Harvard Family Physicians to release any information necessary to file and settle insurance claims, including any third party insurances. I understand I am personally financially responsible to Harvard Family Physicians for all changes not covered by assignment including co-pays, co-insurance and ineligibility.

APPOINTMENTS: Patients are required to arrive at the designated check-in time of their appointment to complete the registration process. Harvard Family Physicians requires at least 24 hours notices prior to any changes to your appointment. Patients who fail to provide proper notice for appointment changes may be subject to a fee as well as a change to a walk-in only status.

PAYMENT: Co-pays, nominal fees or other patient responsibility is due at the time of service. If you are unable to provide payment, arrangements will need to be made with the front desk and/or the billing department.

TREATMENT OF A MINOR:
To ensure that your child will get the necessary attention as timely as possible, you should complete a Consult to Treatment of a Minor Form, which is available at the front desk. This forms gives Harvard Family Physicians permission to treat your child, in your absence, if the need arises.

PRESRIPTION REFILL POLICY: If you need a refill on a previously prescribed medication, please contact your pharmacy. The pharmacist will fax us your request along with current dosages and medications for your healthcare providers approval. Please allow 3-5 business days from the time we receive the fax from the pharmacist for your refull request to be processed.

PATIENT RIGHTS & RESPONSIBILITIES: I, the undersigned, have received the Patient Rights and Responsibilities form. I understand and agree to abide by the conditions for treatment at **Harvard Family Physicians**.

_____ I am the patient _____ I am the Parent/Legal Guardian of the Patient

______________________________ ______________________________
Patient Name Patient DOB

______________________________ ______________________________
Parent/Guardian Name: Relationship to Patient

______________________________ ______________________________
Signature Date