Freedom Mental Health Associates
CONSENT TO TREATMENT

Patient Name: _____ Date of Birth: _____

General Consent

I consent to medical care at Donna Carmosky, MD, PLLC, d/b/a Freedom Mental Health Associates ("**FMHA**"). This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made.

Financial Responsibility

I agree to pay for all services provided. I understand that I may need to call my insurance company to see if it will approve and pay for my medical care at this office. Please bill my health insurance plan as a service to me. I am aware that this does not mean that it will agree to pay for any services. I agree to pay whatever amount is not covered. Please apply for any health insurance coverage that may be available to me. I agree to help in this process. I assign all of my rights and claims for payment under any health insurance plan to FMHA. I appoint FMHA as my "authorized representative" to act for me in getting payment for services provided. If I pay more than what I owe for a medical visit, I agree that such excess payment can be used to pay for any unpaid bills at this office or this office may apply such excess payment to my future bills. I agree that FMHA may charge, and by my signature below I hereby authorize FMHA to charge, the credit card that I have provided to this office all amounts owed to this office, including any copayment or deductible due under my insurance plan, any amounts not covered or paid by, or otherwise denied by, my insurance plan, and all other amounts due and payable to this office, including any fees or charges for missed appointments or appointments cancelled or rescheduled with less than 48 hours' advance notice.

Signature of Individual or Legally Authorized Representative:

_____

Print Name: _____

Date: _____