TREATMENT CONSENT

Patient's Name:_____ Date of Birth:_____

I hereby give my consent for The Frederiksted Health Care, Inc. to provide me and/or my family with medical/or dental care. I understand that no guarantee or assurance is made as to the results that may be obtained.

Guardian Permission to Escort

I_____, as parent or legal guardian of _____, patient of Frederiksted Health Care, Inc. give permission to the following people (must be over 18 years) to escort my child to his or her visits for treatment.

1._____ 2). _____
Relationship:_____ Relationship:_____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with:

☐ _____ (Insurance Company)
☐ Medical Assistance Program (MAP)
☐ Medicare

And assign directly to the FREDERIKSTED HEALTH CARE, INC. all insurance benefits, if any otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges, whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions.

The above-named health center may use my health care information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

TREATMENT AND INSURANCE CONSENT:

(X)_____ _____
Signature of Patient, Guardian or Representative Relationship

_____
Date