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**Consent to Treat**

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give my voluntary consent for Healthy Living Family Medical Center and its healthcare providers, including physicians, nurse practitioners, physician assistants, nurses, and other staff, to conduct evaluations, perform examinations, and provide necessary medical treatment and/or diagnostic procedures as deemed necessary or advisable in the course of my care.

**I understand and agree to the following:**

1. **Scope of Care:**
This consent includes routine services (such as physical exams, immunizations, lab tests, and diagnostic procedures), as well as urgent or follow-up treatments related to my medical condition(s).
2. **Communication and Coordination:**
I understand that my healthcare providers may collaborate with specialists or refer me for additional care, and I authorize the sharing of my medical information with those providers as necessary.
3. **Right to Refuse Treatment:**
I understand I have the right to ask questions about my treatment and to refuse any recommended services.
4. **Electronic Health Records (EHR):**
I consent to the use of electronic systems for the storage and exchange of my medical records as required for my care.
5. **Minors or Dependents (if applicable):**
I attest that I am the parent/legal guardian of the patient named above and have the legal authority to consent to treatment on their behalf.
6. **Financial Responsibility:**
I understand that I am financially responsible for any services provided that are not covered by my insurance, including copayments, deductibles, and non-covered services.

**Patient or Legal Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_