Pandora
FAMILY MEDICINE

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Consent to Treat

Please initial each line and sign at the bottom of this form.

____**I authorize** medical and health care treatment at Pandora Family Medicine.

___ **I understand** that refills, referrals, and letters require an appointment and **will not** be handled by phone, email, or patient portal.

____ **I understand** that Pandora Family Medicine will notify patients of the results of all ordered tests, whether the findings are normal or abnormal.

- Occasionally, test results may not be received by the office. If I have not received results within 14 business days, **I acknowledge it is my responsibility** to follow up and ensure that all test results are reported to me.

____**I acknowledge** that I have reviewed a copy of the Notice of Health Information Privacy Practices and have taken a copy if desired.

____**I authorize** Pandora Family Medicine to release my medical information to:

- Any physician or health care practitioner to whom I am referred, and
- Any payer of my care (e.g., insurance company or managed care program), upon their specific request.
- This also includes applicable records regarding my child, if relevant.

____**I understand** that Pandora Family Medicine respects my privacy and will only release information necessary to:

- Further my treatment,
- Assist in obtaining payment,
- Support internal operations, or
- As specifically authorized by me.

____**I acknowledge** that if I have not been seen in 36 months, I may need to re-establish as a new patient, if openings are available.

____**I understand** that I may revoke these authorizations in writing at any time. Such revocation will not affect my financial responsibility for services already provided.

I also certify thatI am here to receive health care and for no other purpose.

Patient Name (Print):_____ **Date:** _____

Signature :_____ ***(or Guardian's signature if patient is a minor)***

Revised and Finalized on August 26th, 2025.