Tel: 817-769-6339
Fax: 817-719-9336
Email: pshealthservices1@gmail.com

Medical Consent to Treat Form

1. I _____ (patient name) give consent to **PS House Calls** to give me medical treatment.

2. I allow **PS House Calls** to file for insurance benefits to pay for the care I receive.

I understand that:

- **PS House Calls** will have to send my medical record information to my insurance company and that I :
- must pay my share of the costs.
- must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand that I:

- have the right to refuse any procedure or treatment.
- have the right to discuss all medical treatments with my clinician.

_____ _____

Parent or Guardian Signature Date