Consent To Treat Form

1. I_____ (patient name) give permission for [**Anthem Medical Care, PLLC and/or Rachell Phillips**] to give me medical treatment.

2. I allow [**Anthem Medical Care, PLLC and/or Rachell Phillips**] to file for insurance benefits to pay for the care I receive.
I understand that:

- [**Anthem Medical Care, PLLC and/or Rachell Phillips**] will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:

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

_____

Patient's Signature Date

_____

Parent, Guardian, or POA Signature Date

_____

Print Name Date