DELTA HEALTH

2117 Bentley Plaza
Fenton, MO 63026
Phone: 636-825-2200
Fax: 636-825-2201

CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

Consent for Medical Treatment: I voluntarily consent to the medical treatment provided by Delta Health. I consent to drug testing if deemed appropriate by my physician. I am/are aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of treatments or examinations. I acknowledge and agree that if my insurance does not pay my claim within 45 business days, I may be held responsible for the full amount of my claim. I have read this consent and understand and agree to its contents. I understand that the consent for medical treatment, authorization for release of information and assignment of financial responsibility will be valid for the duration of treatment and can only be revoked upon written notice. By signing below, I acknowledge that this consent form has been read in full and explained, as necessary.

Patient/Guardian Signature: _____ Date: _____