**Consent to Treat**

I (patient name) give permission for **Wyoming Medical Associates** to provide me medical treatment for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I allow **Wyoming Medical Associates** to file for insurance benefits to pay for the care I receive.

I understand that:

* **Wyoming Medical Associates** may 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.

I understand that:

* 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 or Guardian Signature Date

(for children under 18)

Print name