

David Greengart, MD  
Midwest Health Center-St Louis

**Patient Consent Form**

All Patients: PLEASE READ AND SIGN AT #1 #2, & #3 PRIOR TO FIRST VISIT

**1) CONSENT FOR TREATMENT**

I, \_\_\_\_\_ (please print name) am voluntarily seeking medical care and treatment from Midwest Health Center-St. Louis and David Greengart, MD, and I give permission to the medical and mental health staff to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations and recommendations they provide me. In addition, I consent to allow staff members to contact me at my home or other location that I specify, and leave a message regarding appointment reminders, billing items, and any calls pertaining to my clinical care, including lab and x-ray results.

\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**2) SECURITY POLICY NOTICE:**

I hereby acknowledge that I have been informed by Midwest Health Center-St Louis and David Greengart, MD, that security cameras on the premises may employ audio and/or video recordings, which may include portions of patient encounters. These devices are employed for security purposes only, and while this information will remain confidential, it may need to be disclosed in the event of civil or criminal litigation.

\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**3) RESPONSIBILITY FOR PAYMENT:**

I acknowledge that payment for services is due in full at the time services are rendered, unless other arrangements are made, and that I am responsible for, and agree to pay, all incurred charges.

\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date