TRI-HEALTH
Family wellness center
2253 Green Hedges Way Suite 101 Wesley Chapel,FL 33544
813-771-6851 813-771-6875
info@trihealthfamily.com

Consent for Treatment

Consent for Treatment: TRI-HEALTH FAMILY WELLNESS CENTER strives to provide the best in the most reasonable care in a patient centric fashion. To achieve that I understand TRI-HEALTH FAMILY WELLNESS CENTER can deploy diagnostic and therapeutic testing or alternative modalities as indicated.

These diagnostic and or therapeutic interventions include utilization of ultrasound, tissue biopsy, scopes such as hysteroscopy, cystoscopy, colposcopy, EKG, injections, utilization of local anesthetic as and when needed. Other testing and or interventional procedures may be needed from time to time and will require verbal consent.

I understand that vast majority of these diagnostic and or therapeutic procedures are extremely safe nevertheless there always remains some risk of pain, infection, bleeding damage to internal organs.
I hereby give permission and consent to TRI-HEALTH FAMILY WELLNESS CENTER deploy diagnostic and/or therapeutic interventions as needed in my case to achieve the best diagnosis and treatment. This is my consent for treatment. I can withdraw my consent for treatment at any time by providing a written notice to TRI-HEALTH FAMILY WELLNESS CENTER.

Assignment of Benefits: I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or operated by TRI-HEALTH FAMILY WELLNESS CENTER including physician services, or by any provider under contract with TRI-HEALTH FAMILY WELLNESS CENTER or participating in a provider network in which TRI-HEALTH FAMILY WELLNESS CENTER or its affiliates participate.

Important Information for Patients: I will obtain the material on each line initialed below.

- ☐ Notice of Privacy Practices www.fl.gov/hippaprivacyinfomation.com
- ☐ Federal and State Patient Rights Information available at www.hhs.gov
- ☐ Health Care Directive Brochure information available at https://www.fl.gov/health

(continued)

TRI-HEALTH
Family wellness center
2253 Green Hedges Way Suite 101 Wesley Chapel,FL 33544
813-771-6851 813-771-6875
info@trihealthfamily.com

Guarantee and Agreement to Pay NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below. I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). I understand that interest per year may be added if the account balance goes to a collection agency.

Signature _____Date _____
Print Name: _____
Signature by: ☐Patient ☐Legal Guardian ☐Proxy ☐Legal Representative