AFFINITY
HEALTH GROUP

Improving Lives, Improving Care

Patient Name: _____

CONSENT TO TREATMENT

1. I hereby voluntarily consent to care at and by Affinity Health Group ("Affinity"), which may encompass certain routine out-patient procedures and certain diagnostic procedures, examinations and medical treatment including but not limited to routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribed by the provider.
2. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by Affinity and its providers as is necessary in the medical staff's judgment.
3. If attached, I have reviewed and understand the supplemental information provided by my physician regarding specific treatment and/or procedures that may be provided.
4. In consenting to treatment, you are authorizing Affinity to send you appointment reminders through automated phone calls and/or text messages. If at any time you no longer want to receive appointment reminders, please advise us in writing (email or letter), and we will discontinue that service.
5. I understand that Affinity consists of primary care, specialty, and other ancillary healthcare providers. Affinity also includes an industrial medicine clinic. Affinity maintains its records electronically. This allows my medical information to be available throughout Affinity.
6. I hereby authorize my insurance carrier(s) to pay Affinity, all benefits due me, if any, by reason of service described in the statements rendered and as provided for by the policy contract with my insurance carrier(s).
7. I understand that this Consent Form will be valid and remain in effect as long as I (he/she) attend any Affinity clinic.
8. This form has been explained to me, along with any attachment, and I understand their contents.

_____ _____

Signature of Patient or Person Authorized to Consent for Patient — Date

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If patient is a minor or is unable to consent, _____
Patient Name

A. Patient is a minor _____ years of age.
   Name of legal Guardian _____
B. Patient is unable to consent because _____

_____ _____

Signature of Person Authorized to Consent for Patient — Relationship

REQUIRED RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of medical information necessary to process my claim. As a courtesy to Affinity's patients, we will file the claim with your insurance carrier with the understanding that if your insurance company does not pay, you are responsible for payment of this account.

Patient (or Guardian): _____ Date_____
Print Sign