**REGENCY HEALING
MEDICAL CLINIC**
*Healing And Preserving Our Community*

Patient Consent for Treatment

 (Please read and sign)_____

I, the undersigned, hereby consent to the following Treatment:
- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be medically necessary or advisable based on the judgment of the attending physician or their assigned designees. This also includes screening for HIV unless the patient declines (opt-out screening) in a separate written document provided to this clinic.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Regency Healing Medical Clinic** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Regency Healing Medical Clinic** to use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Regency Healing Medical Clinic.**

I acknowledge that I have been given **Regency Healing Medical Clinic** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____          _____

Patient (or Responsible Party) Signature                              Date