Outpatient Treatment Consent Form

Patient Name

Date of Birth

Date

Consent for Treatment

I hereby voluntarily consent to outpatient care and treatment including diagnostic procedures, examinations, and medical or mental health treatment as considered necessary and advisable by the healthcare providers of this facility.

Confidentiality

I understand that all information shared during treatment is confidential and will not be released without my written consent, except as required by law.

Patient Rights

I have been informed of my rights as a patient including the right to refuse or discontinue treatment at any time, understanding the potential consequences of such refusal or discontinuation.

Financial Responsibility

I acknowledge that I am financially responsible for all charges for services rendered and agree to provide accurate billing and insurance information as required.

Signature

Patient/Guardian Signature

Date

Relationship to Patient (if applicable)