

Consent to treat and privacy acknowledgement

Please read, ask us anything, then sign. You can ask for a copy of this page at any time.

Consent to treatment

I ask Alder Health and its providers to examine and care for me, or for the patient named below. I understand my provider will explain what they find and what they suggest, and that I can ask questions and say no to any test or treatment at any time.

I understand that no one can promise a particular result, and that I can end my care here whenever I choose.

Payment

I understand I am responsible for my copays, deductible and any amount my insurance does not pay. I understand I can ask for a price before any test or procedure, and ask about a payment plan.

Privacy notice

I was offered a copy of the Alder Health notice of privacy practices. It explains how my health information may be used and shared, and my rights to see my records, ask for corrections and ask for a list of disclosures. The notice is also at clinic.phoenixcodes.org/privacy.

Who may we speak to about my care, besides me?

- ☐ No one else ☐ The people I list below

Name	Relationship	Phone
Name	Relationship	Phone

Signatures

Patient name (print)	Date of birth
Signature of patient, parent or legal guardian	Date

If signed by someone other than the patient, print name and relationship