Aspen Family Medicine at Green Valley Ranch

Patient Consent Form

(Please Read and Sign)

I, the undersigned, herby consent to the following Treatment

- Administration and performance of all treatment
- Performance of such procedures as may be deemed necessary or advisable in treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/test
- Performance of other medically accepted test that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

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

I intend this consent to be continuing in the 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 **Aspen Family Medicine (an affiliate of HealthONE Physician Care)** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Aspen Family Medicine** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of the 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 **Aspen Family Medicine**.

I acknowledge that I have been given the **Aspen Family Medicine**, Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

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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**

_____ _____

Witness **Date**