615 Cumberland Street, Lebanon, PA 17042
Phone: 717-273-6741
Fax: 717-273-6337

General Consent Form

I, the undersigned, have requested the services provided by **Lebanon Family Health Services**. The possibility of complications from medication and/or treatment will be discussed with me. If it is necessary for me to take medication, I am prepared to accept the risks related to such treatment and I request such treatment as deemed necessary. I hereby authorize a clinic staff physician or his/her designated practitioner to render such services.

I realize that if tests are taken for sexually transmitted diseases, reporting of certain positive results to public health agencies is required by law.

Further, I have been instructed, and I understand that should any unusual symptoms occur, it is my responsibility to immediately report these symptoms to the staff physician or designated practitioner at **Lebanon Family Health Services**. **I understand that if I develop any unusual symptoms and the clinic staff at Lebanon Family Health Services is not available, that I will go to the Emergency Room or call my primary care doctor.** In addition, I understand that I must report for regular checkups as recommended.

Referral will be made for further diagnosis and/or treatment where indicated. I also understand that if follow up is needed I will assume responsibility for such follow-up. I consent to have necessary medical information forwarded to a physician of my choice for necessary follow up. I also authorize the release of any medical information necessary to process any insurance claims.

I understand that I may withdraw my consent and discontinue my services at any time in the future by informing this clinic of such intent.

I understand that I am financially responsible for any and all costs incurred by me for services rendered that are not covered by my health insurance. I am fully aware that my insurance does not guarantee coverage. My carrier may reject my claim for various reasons, included but not limited to:

- **Policy exclusions of procedure**
- **No or limited maternity benefits for dependents**
- **Overage clause for dependents**
- **Pre-existing medical conditions**
- **Deductibles**

I authorize payment of medical benefits directly to **Lebanon Family Health Services** for services on this date only when applicable fee has not been paid in full by me at the time of services.

I certify that no warranty, guarantee or assurance of any kind has been made to me by any member of the clinic staff as to the results of services to which I hereby consent. I am executing this form with full understanding of the meaning of my consent and I do so freely and voluntarily.

KTD 12/7/16