Lebanon
FAMILY
HEALTH
Services

615 Cumberland Street
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.

I understand that all services are confidential and provided solely on a voluntary basis.

I realize acceptance of Family Planning Services is NOT a prerequisite for eligibility for other services.

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 may 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.

PHYSICAL PATIENTS

The physical we are providing you today is for a specific purpose and should not take the place of comprehensive medical care with your doctor. It is important to continue your routine checkups as scheduled.

We are happy to assist you with any of our other medical services. We offer a variety of scheduling options to meet your needs. Feel free to contact our office for more information.

Lebanon Family Health Services will not discriminate against any employee, applicant for employment, independent contractor, client, or any other person based on race, color, religious creed, national origin, age, sex, sexual orientation, gender identity, gender expression, genetic information, marital status, veteran status, parenthood, disability or any other characteristic protected by law.

Patient Signature: