Delta Medical Foundation Clinic Consent to Treat

Family Medical Center, Marks Mississippi - Warrington Clinic, Clarksdale Mississippi - Delta Medical Health & Wellness, Batesville Mississippi - Diabetic Solutions Center, Marks Mississippi

CONSENT TO TREAT

I hereby consent to authorize the professional staff at the Delta Medical Foundation to furnish any and all diagnostic and therapeutic services and supplies to which I may from time to time require for treatment of my medical condition(s) then existing, and including but not limited to:

Medical history
Physical examination
Assessment of health status
Laboratory testing
Emergency procedures
Suturing
Incision and drainage
Ear lavage
Skin tag removal
Wound care
Women's health (pap smear, pelvic exams, and vaginal cultures)
Medications
Immunizations

I acknowledge that I may at any time request information from the professional staff at the Clinic as to any diagnostic and therapeutic services or supplies rendered to me.

I acknowledge that I have read this consent (or have had this consent read to me) and understand its contents.

Billing and Payment

Delta Medical Foundation participates with many, but not all insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is in network with them. It is also your responsibility to provide accurate insurance information prior to the service. If you do not have your up-to-date insurance information, we will reschedule your appointment or classify your appointment as self-pay. Clinic services may not be covered by all insurance plans. If your insurance does not cover the Telehealth visit, you will be considered self-pay, and our published self-pay fee will apply. Non-covered Telehealth visits will be the patient's responsibility.

If any questions or concerns about the consent, please contact Delta Medical Foundation at 662-326-3500. Mailing address: P O Box 289, Marks, MS 38646.

Patient's Authorized Representative for Consent if not Patient (Last, First) _____

Consent Date (MM/DD/YY) _____

Signature for Patient's or

Patient's Authorized Representative Consent _____