INFORMED CONSENT FOR TREATMENT

I hereby authorize Axis Community Health affiliated physicians, providers and staff to administer medical treatment which may now or during the course of care be deemed advisable or necessary.

I acknowledge that I am legally responsible for all charges in connection with medical care and treatment provided by Axis Community Health. Treatment charges may include, but are not limited to, provider visits, nurse visits, lab tests, medications, supplies, and equipment.

I am also responsible for understanding my insurance and/or health care program coverage and restrictions and for immediately notifying Axis Community Health whenever there is a change in information necessary to process the claims.

I understand that I have a right to file a complaint/grievance if I am not comfortable with medical decisions that directly affect me. I have the right to appeal to supervisory staff or the Chief Operating Officer.

I understand that I have a right to file grievance directly with regulatory agencies even if I have not filed a grievance with Axis. My decision to file a complaint/grievance will not compromise my care. All information regarding the grievance/complaint will be kept confidential.

Patient / Representative Signature:_____ **Date**:_____

If signed by someone other than the patient:

Representative Print Name:_____

Representative Relationship to Patient:_____