Promise
Healthcare

Adult Consent for Treatment

I, _____, hereby authorize Promise Healthcare staff to provide care on my behalf and to have access to information necessary for the delivery of services.

- I understand that in an emergency situation care will not be delayed, and this consent will be signed as soon as possible thereafter.
- I authorize Promise Healthcare to make appropriate referrals on my behalf.
- I understand that Promise Healthcare works collaboratively with teaching institutions in the community, and I may see a resident or intern.
- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to Promise Healthcare.

Forms are valid for 12 months after the date of signature or until such agreement is revoked by patient in writing.

Patient Name: _____ Date of Birth: _____

Patient Signature:_____ Date: _____

Other Signature: _____ Date: _____
(*if not completed by patient and appropriate documentation has been received*)

STAFF USE ONLY

Received by: _____ Date Received: _____

Form revised 03/18/2024