

Consent to Treatment

[Buford Care Inc.]

I hereby give my permission for **Buford Care Inc.** to give me medical treatment.

I allow Buford Care Inc. to file for insurance benefits to pay for the care I receive.

I understand that:

- the Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
- **I give Buford Care Inc. the right to perform diagnostic tests, procedures, venipunctures, etc, unless I refuse**
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

Signature of the patient or Legal Guardian

Patient's Name: