Frontier
INFUSION CENTER

CONSENT TO TREAT

I, the undersigned voluntarily give consent to Frontier infusion Center to provide and perform such medical/ diagnosis/ minor surgical treatment (s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition (s) or to maintain my health. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ _____

Patient Signature Date

RECEIPT OF OFFICE POLICIES & PROCEDURES AND PRIVACY NOTICE

I have received/reviewed a copy of Frontier Infusion Center "office policies and procedures for our patients" and "Notice of privacy practices" and the Texas Patient Bill or rights.

_____ _____

Patient signature Date

RELEASE OF HEALTH INFORMATION

1.- Frontier Infusion Center and its staff adhere to a policy of not releasing protected health information to individuals other than the patient. If you choose, you can designate others to receive your health information (check or put N/A below).

☐ I authorize Frontier Infusion Center to release protected healthcare information about myself to the following individual.

Name_____ Relationship_____

I Understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

2.- The Texas Department of State health Services (DSHS) consolidates immunization records for public health purposes and encourages your voluntary participation in the Texas immunization Registry. More information can be found at www.immtrac.com (check or put N/A below).

☐ I authorize Frontier Infusion Center to register and release my immunization records to authorized person/entities.

_____ _____

Patient Signature Date