PLEASANT RIDGE
INTERNAL MEDICINE

CONSENT TO TREAT

I _____ (patient name) give permission for Pleasant Ridge Internal Medicine and its affiliates to give me medical treatment.

I allow Pleasant Ridge Internal Medicine and its affiliates to file for insurance benefits to pay for care I receive.

I understand that:

Pleasant Ridge Internal Medicine may 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.

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

_____ _____

Patient's Signature Date

_____ _____

Pleasant Ridge Internal Medicine Date