BUILDING HEALTHY LIVES TOGETHER

Family Health Services of Darke County, Inc.
GENERAL CONSENT FOR TREATMENT

Patient's Full Name: Date of Birth:

General Consent to Treatment

I, _____ *(Print name of patient or personal representative)* hereby request and authorize Family Health Services of Darke County, Inc. ("Family Health Services") and its personnel to provide routine medical, dental, vision, and behavioral health care that may be deemed necessary or advisable.

Care may include, but is not limited to:

- Medical evaluation, physical examination, diagnosis, and prescriptions/therapeutic recommendations for condition
- Review of medical history, including history of sexual, mental, or emotional trauma
- Dental cleanings and dental x-rays
- Immunizations and therapeutic injections
- Collection of specimens (such as blood, urine, swabs, or other samples) in the office and/or the submission of these specimens to a laboratory for testing, as clinically indicated
- Skin lesions with liquid nitrogen
- Treatment of minor burns
- Minor suturing of lacerations
- Speech Therapy services
- Behavioral Health care that may be deemed necessary or advisable in the diagnosis and treatment of the patient
- Psychiatry services
- Vision Services

A Family Health Services provider will review patient history before making any new diagnoses. I consent to the rendering of all medically necessary treatment.

Financial Responsibility

I understand that I am financially responsible for the cost of services not covered by a third-party payor. Payment is expected at the time of service. I understand that my income may be used to determine my eligibility for a financial need discount and my financial responsibility for services to which I consent.

Limitations on This Authorization

Please identify any specific limitations on the kinds of services authorized. If there are no limitations, please check the box:

☐ None

_____

_____

Parent/Guardian Authorization for Minor Patient

If a minor patient arrives accompanied by someone other than their parent or legal guardian, or arrives unaccompanied, the parent or legal guardian must have authorized that adult to act on their behalf. If the minor is legally permitted to consent to their own health care services, they may receive such services even if unaccompanied.

Please list all adults authorized to consent to the minor patient's care:

Name 1: Phone: Relationship to Patient:

Name 2: Phone: Relationship to Patient:

Revision Date: 7/22/2026

Name 3: Phone: Relationship to Patient:

Patient or Personal Representative Attestation

By signing below, I voluntarily give my consent as described in this form. I attest that I am legally authorized to consent to services provided by Family Health Services. My signature confirms that I have read this consent form, or that it has been read to me and explained in a language I understand. This consent is effective for one year from the date signed and may be revoked in writing at any time.

Signature of Patient or Personal Representative: Date:

Printed Name: Date:

If you are the representative of a patient, select the scope of your authority to act on the patient's behalf:

❒ Parent ❒ Power of Attorney ❒ Legal Guardian ❒ Surrogate Decision-Maker

❒Biological Parent ❒ Executor or Personal Representative ❒Other: