SIMON DIRECT
PRIMARY CARE
DEDICATED TO HEALTH. COMMITTED TO CARE.

MEDICAL TREATMENT CONSENT FORM

Single Visit

PATIENT NAME:_____ PATIENT DATE OF BIRTH:_____

Consent for treatment:

Knowing that I (or the patient indicated on the top of this form) desire a one-time evaluation and/or treatment (an "urgent care visit") at Simon Direct Primary Care, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory services, administration of medication and to medical or surgical treatment by physicians and staff members of Simon Direct Primary Care and other healthcare providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. 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 the result of my examination or treatment at Simon Direct Primary Care. I acknowledge that treatment is intended to address specific episodic illness or injury and is not intended to substitute for comprehensive care in lieu of a primary care physician or other specialized physician. To provide the best chance for successful treatment I accept responsibility to follow the advice of my treating physician including compliance with medications discharge instructions and reevaluation with follow-up or referral physicians. I agree to return to the clinic or seek care in an emergency department of a hospital if my condition changes. I further agree to hold harmless the physicians and staff of Simon Direct Primary Care should I fail to comply with the above conditions. I understand that a single "urgent care visit" does not constitute a comprehensive primary care physician-patient relationship.

Numerous benefits are available to our regular members, including after-hours phone, e-mail, and text, and social media access. These are not benefits provided to patients who receive an urgent care visit.

Urgent care visits will be charged to me in cash, and payment expected, at the time of service. The cost will be communicated to me by the physician before care is given. I understand that I will not request insurance, Medicare, or Medicaid to reimburse any part of this visit.

Patients at Simon Direct Primary Care will be treated regardless of race, color, age, national origin, disability, or religion. Notwithstanding the above criteria, Simon Direct Primary Care reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior, or any other reason at the discretion of the physician on duty.

This consent shall remain in force until such time as it is specifically revoked.

Signature of patient/patient representative: _____Date: _____
(Representative signature is required if the patient is a minor or unable to consent)

Representative's relationship to patient: _____

Witness: _____ Date: _____