ELEMENT
ENDOCRINOLOGY & DIABETES

Consent To Receive Medical Care

Element Endocrinology and Diabetes, PLLC

1. I _____ give permission for Element Endocrinology and Diabetes to give me medical treatment.

2. I allow Element Endocrinology and Diabetes to file for insurance benefits to pay for the care I receive.

   I understand that:

   - Element Endocrinology and Diabetes 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.

3. I also understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date

(for children under 18)

_____

Print Patient Name