New Heights
Health & Wellness

General Consent for Treatment

Patient Name: _____ **DOB:** _____

Purpose

This form gives consent for routine medical care provided by **New Heights Health and Wellness**.

Consent for Care

I voluntarily consent to care and treatment by the providers and staff at **New Heights Health and Wellness**, including but not limited to:

- Medical history, physical exams, and routine diagnostic procedures
- Administration of medications, vaccines, and injections
- Laboratory tests, imaging, and other diagnostic studies
- Minor office-based procedures as needed
- Coordination of care with other providers when appropriate

I understand that this consent applies to routine care. If more invasive or high-risk procedures are recommended, I will be informed and asked to provide separate, specific consent.

Patient Rights

- I have the right to ask questions about my care at any time.
- I may refuse treatment, and I understand that my refusal may affect my health outcomes.
- I understand that all information related to my care will be kept private as required by law (HIPAA).

Release of Information

I authorize the release of necessary medical information to other healthcare providers, facilities, and my insurance company for purposes of treatment, payment, and healthcare operations.

Financial Responsibility

I understand that I am financially responsible for all services provided, including any portion not covered by my insurance.

Consent Acknowledgment

By signing below, I confirm that:

- I have read and understood this consent form.
- I have had the opportunity to ask questions.
- I voluntarily agree to receive care and treatment at **New Heights Health and Wellness**.

Patient/Guardian Name (print): _____

Relationship (if not patient): _____

Signature: _____

Date: _____

Provider/Staff Witness: _____ **Date**: _____