CONSENT TO TREAT

1. I,_____ give permission for Families Together of Orange County to provide medical, dental, vision, and/or behavior services. The following are examples of services that may be rendered:

Family Practice, OB-GYN, Pediatrics, Comprehensive Basic and Major Dental, Orthodontic, Optometry, Behavioral Therapy, Family Planning, Nutritional Counseling, Acupuncture, Chiropractic, Physical Training, Pharmaceutical Assistance, Sexual Reproductive (e.g., STD and HIV testing), as well, any and all additional services within the scope of practice at Families Together of Orange County.

2. I allow Families Together of Orange County to file for insurance benefits to pay for the care I receive.

I understand:

- I will be provided a copy of my medical records upon request.
- I may be referred to outside agencies for additional care, if medically necessary.
    - These agencies will have access to my medical records that are deemed necessary to providing additional care.
- I am responsible for any and all charges in accordance with the Families Together of Orange County Sliding Fee Scale discount program policy, a copy of which is available on request.
- I have the right to refuse any procedure or treatment.

*Consent will remain effective unless it is revoked in writing and delivered to:

Families Together of Orange County
661 W 1ST ST STE G
Tustin, CA 92780

_____
Signature of patient, parent, or guardian, as appropriate