sunrise
COMMUNITY HEALTH
affordable access, quality care, for all

CONSENT TO BE TREATED

I, _____ acknowledge and consent to the health care services rendered at this facility. I understand that I am responsible for making my co-payment. I agree to pay co-payments at the time of service unless other arrangements have been made in advance. I authorize the release of any health records necessary to secure the payment of benefits and authorize the use of this signature on all my insurance submissions. I also, understand that in the event that my insurance or discount doesn't cover a service, that I am responsible to pay for any denied claims or non-covered benefits.

First and last name of children under 18	Date of Birth
_____	_____ / _____ / _____
_____	_____ / _____ / _____
_____	_____ /_____ / _____
_____	_____ / _____ / _____
_____	_____ / _____ / _____

_____ _____/_____/_____

Patient or Designated Representative Signature — Date