# Consent for Evaluation and Treatment

**Family Medical Centers (FMC) is dedicated to providing comprehensive primary care, dental and** behavioral health services to Ohio residents. Because wellness involves both the body and mind, our multi-disciplinary team of providers work together to offer you high-quality whole person healthcare. In order to provide you with comprehensive and coordinated care, your providers may involve other healthcare specialists as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure enhanced continuity of care.

Some services at Family Medical Centers may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet, or saved in any way.

I understand, that if I am 16 years of age or older, I may consent for certain types of health services, including mental health services; if I am 18 years of age or older, I may consent for all other health services; otherwise, my parent or legal guardian will need to consent to services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

I consent to the use of my medical information necessary for transmission of prescriptions to the pharmacy and as needed for the coordination of formulary and/or benefits eligibility with my insurance provider. I consent to the query of my external prescription history as necessary to manage my healthcare and related services.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or child(ren) as set forth above, including any studies or procedures that FMC professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

My signature below serves to confirm I have received information on how obtain a copy of the Family Medical Centers' Notice of Privacy Practices as well as the Patient Rights and Responsibilities

Patient/Guardian:_____