Consent to Treat Form

1. I ___[redacted]___ (patient name) give permission for **University of Kentucky Medical Center** to give me medical treatment.

2. I allow **University of Kentucky** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **University of Kentucky Medical Center** 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 understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

[redacted] 1/25/2022

Patient's Signature Date

Parent or Guardian Signature Date
(for children under 18)

[redacted] 1/25/2022

Print name