Patient Label
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Sycuan Medical Dental Center
Tel: (619) 445-0707
Website: https://www.sycuanmedicaldentalcenter.org

GENERAL CONSENT FOR TREATMENT

Thank you for choosing Sycuan Medical Dental Center as your primary medical and/or dental healthcare provider. We are committed to providing you with the highest quality of care. We ask that you read and sign this form to acknowledge your understanding of our general consent for treatment policies.

CONSENT FOR TREATMENT: I voluntarily consent and authorize such care and treatments, including but not limited to a physical or mental examination, diagnostic tests, medical procedures, dental procedures, and medications by employees and authorized agents of Sycuan Medical Dental Center ("SMDC") including all affiliated providers, dentists, nursing staff and other ancillary providers, as may be considered necessary or advisable in their professional judgment. I am aware that the practice of medicine is not an exact science and further acknowledge that no guarantees have been made regarding the effect such treatments may have on any medical condition. As part of this Consent, I affirm that I have accurately and truthfully disclosed my health history, pre-existing conditions, and medications to the SMDC.

RIGHT TO REFUSE TREATMENT: I understand that I have the right to make informed decisions regarding all care, and treatments and that I may ask the health care professional to explain anything that is not understood. This right includes the right to refuse any treatments.

RELEASE OF INFORMATION: I authorize Sycuan Medical Dental Center employees and affiliates to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans, and third-party payers including employers, health service plans or worker's compensation carriers.

5442 SYCUAN ROAD, EL CAJON, CA 92019
ADMIN OFFICE FAX (619) 445-9764 • DENTAL FAX (619) 445-5419 • MEDICAL FAX (619) 445-0988

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ASSIGNMENT OF HEALTH BENEFITS: I authorize and instruct the insurance carrier to make payment directly to Sycuan Medical Dental Center for any medical or dental benefits otherwise payable to me or my guarantor as payment toward the total charges for co-payments, co-insurance, and non-covered services are my or my guarantor's financial responsibility.

NOTICE OF PRIVACY PRACTICE: I acknowledge having received the Notice of Privacy Practices which outlines which health information may be used or disclosed. I consent to such disclosures as delineated in the Notice of Privacy Practices and understand that this may include information related to HIV/AIDS, behavioral health services, and treatment for alcohol and/or drug abuse.

ADVANCED DIRECTIVES: Adults 18 and older have the right to: (a) give direction about their future medical care or (b) designate a patient representative to make medical decisions for them if they lose individual decision-making capacity. I understand that information about advance directives is available to me upon request.

I have executed an Advance Directive. □ Yes □ No
(if yes please provide us with a copy).

I would like further information for advance directives. □ Yes □ No

Print Patient Name: _____

Patient or Representative Signature: _____ Date: _____

(If signed by someone other than the patient, please specify the relationship to the patient):

_____

Print Witness Name: _____ Date: _____