



Rapides Regional Physician Group

Practice Name _____

Patient General Consent to Treat

I, the undersigned, hereby consent to the following;

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Rapides Regional Physician Group** may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize **Rapides Regional Physician Group** to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Rapides Regional Physician Group**.

I acknowledge that I have been given **Rapides Regional Physician Group's** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. *Patient Initial* _____

I, the undersigned, authorize **Rapides Regional Physician Group** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or responsible party) Signature

Date