Physicians of Southern California

Phone: 626-859-2249 Fax: 626-859-2248

**Patient Consent to Treat Form**

1. I give permission for **Physicians of Southern California** to give me medical treatment.
2. I allow **Physicians of Southern California** to file for insurance benefits to receive payment for the care I receive.

I understand that:

* **Physicians of Southern California** 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.

1. I understand:

* I have the right to refuse any procedure or treatment.
* I have the right to discuss all medical treatments with my clinician.

Patient’s Signature Date