Consent to Treat

Patient Authorization for Medical Treatment Services

PATIENT INFORMATION

Patient Full Name: _____ **Date of Birth:** _____

Address: _____

Phone: _____ **Email:** _____

CONSENT FOR TREATMENT

I, the undersigned patient (or authorized representative), hereby consent to and authorize **Vitality Health At Your Door** and its physicians, including Dr. Shiv Goel, MD, and designated clinical staff, to provide medical evaluation, diagnosis, and treatment as deemed necessary by the attending physician. This includes but is not limited to:

- Physical examinations and clinical assessments
- Diagnostic testing, including laboratory work and imaging orders
- Wound care assessment, treatment, debridement, and dressing changes
- Medication prescribing, adjustment, and reconciliation
- IV hydration and infusion therapy
- Telehealth consultations and remote patient monitoring
- Care coordination with specialists, hospitals, pharmacies, and facilities
- Clinical documentation and record-keeping

I understand that medicine is not an exact science and that no guarantees have been made to me regarding the outcome of any examination, treatment, or procedure. I acknowledge that I have the right to refuse any treatment or procedure at any time.

I understand that my physician may need to consult with or refer me to other healthcare providers, and I consent to the sharing of my medical information for continuity of care purposes, in accordance with HIPAA regulations.

I acknowledge that I have been given the opportunity to ask questions about my care and that my questions have been answered to my satisfaction.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for any charges not covered by my insurance plan. I authorize Vitality Health At Your Door to bill my insurance company and to release necessary medical information for claims processing. I agree to pay any copayments, deductibles, or non-covered services as determined by my insurance plan.

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____

If signed by someone other than the patient:

Reason patient cannot sign: _____