OPSAM HEALTH
Caring for the Community Since 1973

CONSENT TO TREATMENT

NATURE OF SERVICES: I understand that as a Federally Qualified Health Center (FQHC), Opsam Health provides comprehensive primary healthcare services, including but not limited to preventive care, chronic disease management, behavioral health services, and dental services.

PURPOSE OF TREATMENT: I understand that receiving healthcare services from Opsam Health aims to promote and maintain my overall health and well-being, prevent, and manage diseases, and address any current health concerns.

CONFIDENTIALITY AND PRIVACY: I understand that my health information will be treated as confidential and will be protected in accordance with applicable laws and regulations. I authorize Opsam Health to use and disclose my health information for treatment, payment, and healthcare operations as outlined in their Notice of Privacy Practices.

TREATMENT RISKS AND BENEFITS: I understand that every medical procedure, treatment, or intervention carries certain risks and benefits. The healthcare provider will explain the potential risks and benefits of any proposed treatment or procedure, and I have the right to ask questions to ensure my understanding.

ALTERNATIVE: I understand that I have the right to be informed of any reasonable alternatives to the proposed treatment, including any alternative procedures, therapies, or medications that may be available. I have the right to discuss these alternatives with my healthcare provider and make an informed decision regarding my care.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for any changes or fees associated with the healthcare services provided by Opsam Health. I agree to cooperate with Opsam Health to promptly address any financial obligations and provide accurate insurance information, if applicable.

HEALTH CONNECT: I have authorized the transfer of my information to San Diego Health Connect (SDHC) and know that I can opt out of SDHC at any time by notifying Opsam Health staff.

CONSENT TO TREATMENT: I hereby give my informed consent to Opsam Health and its healthcare providers to administer necessary healthcare services, treatments, procedures, and medications as they deem appropriate for my care. I understand that I have the right to refuse or withdraw consent at any time, and it will not affect my right to future care or treatment.

CONSENT TO TREATMENT OF A MINOR (IF APPLICABLE): As the parent or legal guardian with authority to consent on behalf of the minor child named below, I hereby give my consent to the treatment of the minor from the staff associated with/or employment by Opsam. The proposed treatment plan has been explained to me, the general nature and extent of the risks involved, and alternative treatment options, if any. This consent will be valid until the minor reaches the age of 18.

I have had the opportunity to read and understand this Consent Form, and I have discussed my questions and concerns with my healthcare provider. By signing below, I acknowledge that I am providing my informed consent to receive healthcare services from Opsam Health.

Patient Name: _____Patient/Guardian/Conservator Signature: _____

Relationship: _____ Date: _____ Time: _____

Witness Name: _____ Witness Signature: _____