Consent for Treatment

I, [PRINT NAME] _____, hereby authorize Priority Care Boston and associated staff to provide medical treatment and healthcare services deemed necessary for my care. I understand that treatment may include examinations, procedures, diagnostic tests, and medications as determined by my healthcare provider.

I acknowledge that I have been informed of the nature and purpose of the proposed treatment, as well as any risks, benefits, and alternatives. I understand that I have the right to ask questions and receive additional information regarding my treatment options.

I consent to the disclosure of my medical information to necessary healthcare professionals involved in my care and to billing and administrative personnel for the purpose of processing payments and coordinating services.

I understand that I have the right to refuse treatment, and I have discussed any concerns or questions I may have with my healthcare provider. I agree to adhere to the recommended treatment plan and follow-up care instructions to the best of my ability.

I acknowledge that no guarantees have been made regarding the outcome of treatment, and I release Priority Care Boston and its staff from any liability arising from the provision of treatment, except in cases of negligence.

I consent to the use of a virtual scribe. This is an AI software program that records and structures medical notes from our conversations. The note produced is edited and finalized by the clinical provider staff member who treated you.

Patient's Signature: _____

Parent/Guardian Signature (if patient is a minor): _____

Date: _____

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