BLISS SPECIALTY HEALTHCARE GROUP

Consent for Primary Care Services

Consent for Treatment

I_____ hereby authorize Bliss Specialty Healthcare Group and its providers to deliver primary care services, including but not limited to:

- Routine medical evaluations and follow-up visits
- Management of chronic and acute medical conditions
- Ordering of diagnostic tests, labs, and imaging
- Prescribing of medications and medical treatments
- Care coordination with specialists, hospitals, and pharmacies

Patient Rights

I understand that I may withdraw this consent at any time in writing.
I acknowledge that my participation is voluntary and that I may seek care from another provider at any time. I have received information about my rights under HIPAA regarding confidentiality and access to my medical records.

Insurance & Billing

I authorize the release of medical information necessary to process claims for payment of services rendered. I assign benefits directly to Bliss Specialty Healthcare Group for services provided. I understand that I am financially responsible for any charges not covered by insurance.

Consent & Acknowledgment

By signing below, I acknowledge that I have read, understand, and agree to the above terms and consent to treatment by Bliss Specialty Healthcare Group.

_____ _____

Patient signature / Date **Witness signature / Date**

_____ _____

POA or Guardian Signature/Date ***Relationship to Patient***

OR

VERBAL CONSENT: VIA TELEPHONE
Name of Responsible Party: _____
Responsible Party Phone Number: _____
Responsible Party email Address: _____
Date/Time Verbal Consent Obtained: _____
Verbal Consent Obtained: _____
Signature of the person who obtained verbal consent: _____
Name of the witness of verbal consent: _____
Signature of the witness of verbal Consent: _____

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