Chautauqua Physical & Occupational Therapy TCC

Riverwalk Center
15 South Main Street
Jamestown, NY 14701
P (716) 488-2322
Fax (716) 488-2574

Mayville Professional Building
99 East Chautauqua Street
Mayville, NY 14757
P (716) 224-4099
Fax (716) 224-4999

Park Avenue & Third
51 E. 3rd Street
Dunkirk, NY 14048
P 363-2244
Fax (716) 363-2245

General Consent for Care and Treatment

TO THE PATIENT:

This consent provides us with your permission to perform reasonable and necessary MEDICAL, DENTAL AND BEHAVIORAL HEALTH examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite offices under common ownership of The Chautauqua Center, including visits that are conducted through telehealth (audio and video) means. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue at any time services being provided.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, mid-level provider (Nurse Practitioner, Physician Assistant or Registered Nurse, Licensed Social Worker/Counselor, Dentist or Dental Hygienist, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary examination, testing and treatment for the condition which has brought me to seek care at this practice, including immunizations reported to NYSIIS.

I certify that the insurance information which I have provided is complete and correct. I accept the responsibility of advising and providing TCC, prior to service, of no fault or workers' compensation information for treatment of eligible inquires or illnesses. I authorize TCC to release medical, behavioral health and/or dental information necessary to process insurance claims and release information back to my physician. By my signature below, I hereby consent to treatment, assignment of financial benefits directly to The Chautauqua Center and any associated healthcare and/or dental entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consents.

_____ _____
Print Patient's Name **Date**

_____ _____
Signature of Patient or Parent/Guardian **Date**

_____ _____
Print Name of Parent/Guardian **Relationship to Patient**

_____ _____
Signature of Witness **Date**

Form revised December 10, 2022