Consent to Treat Form

1. I hereby give permission for Charleston Thyroid Center to give me medical treatment.

2. I allow Charleston Thyroid Center to file for insurance benefits to pay for the care I receive.

   I understand that:
   - Charleston Thyroid Center will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

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Patient or Guardian Signature Date