CareBridge Health
Your bridge to better health

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Consent for Treatment and Services

I voluntarily consent to receive medical evaluation, treatment, and services from CareBridge Health and its clinicians, including examinations, diagnostic testing, procedures, telehealth visits, and coordination of care as deemed appropriate.

I understand that the practice of medicine is not an exact science and that no guarantees have been made regarding the results of evaluation or treatment.

Telehealth: I consent to the use of telehealth technologies when appropriate. I understand that telehealth involves electronic communication and that reasonable safeguards are used to protect my information.

Release of Information: I authorize CareBridge Health to obtain and release medical information as necessary for treatment, payment, and health care operations, in accordance with HIPAA regulations.

Financial Responsibility: I agree to be financially responsible for charges associated with my care, including membership fees, visit fees, and services not covered by insurance.

Right to Ask Questions: I have had the opportunity to ask questions about my care and this consent and understand that I may withdraw consent at any time.

Patient Information

Patient Name:	
Date of Birth:	
Phone:	
Signature:	
Date:	