Plum Creek Medical Group, P.C.

1103 Buffalo Bend, Lexington, NE 68850

CONSENT TO TREAT

Patient Name: _____ DOB: _____ Date: _____

By signing this form, I voluntarily consent to receive medical treatment from the medical staff and nursing team at Plum Creek Medical Group. Medical treatment may include, but are not limited to, interview, examination, tests and procedures and deemed appropriate by the treating provider.

Permission for evaluation and treatment is also granted if the above named patient is a minor, whether accompanied by the parent, other family member, unrelated person or unaccompanied.

_____ _____

Patient signature (If self) *Date*

_____ _____

Parent or representative signature (If minor) *Date*

Interpreter's statement:

I have read him/her the authorization form in _____and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____

Interpreter's Signature