

LOGAN PRIMARY CARE

CONSENT TO TREAT

This is to certify that on this date I, _____, give my consent to Logan Primary Care Service Corp. and its medical staff to include licensed nurses, physician assistants, and/or physicians, within the guidelines of the state, to provide medical care and treatment for any injury or illness that should arise and require medical attention.

Any information regarding my health insurance and coverage should be presented to the front desk.

Signature: _____ Date: _____

Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

Phone: (_____) _____