# Traverse Health Clinic and Coalition
# D.B.A. Traverse Health Clinic
## Consent for Treatment

**Patient Name: _____ Date of Birth: ____/____/____**

I am signing this consent form

_____ On my own behalf (I am the Patient who is 18 years of age or older)

_____ On behalf of the Patient for whom I am the **parent/legal guardian/patient advocate-durable power of attorney for health care**

I am voluntarily asking Traverse Health Clinic healthcare providers to provide health care services to me at Traverse Health Clinic (the Clinic). I understand that the Clinic provides both primary care services and behavioral health services. I also understand that no treatment plan has been identified for me as of yet, but I am giving permission to the healthcare providers to do the reasonable examinations and tests necessary to come up with a plan for my care. Before any examinations/tests are performed, I will be told why my healthcare provider thinks they are necessary; I will be able to ask any questions I have about the examinations/tests; I will be told what concerns there are for my health if the examinations/tests are not done and I will be told about possible harmful things that might happen because of these examinations/tests.

If a specific procedure or treatment is needed, I understand my healthcare provider will discuss this with me, will give me a chance to have my questions answered and let me know what else, if anything, can be done to meet my healthcare needs before asking me to sign a consent form for a procedure or treatment.

I understand that I will be asked to sign a separate consent for vaccine(s) to be given to me and that I will receive a “Vaccine Information Statement” (VIS) before I receive each vaccine. (The VIS lists what disease(s) the vaccine protects against, who should receive the vaccine, and possible side effects of the vaccine might cause).

I understand that this consent will be in effect as long as I am a patient of the Clinic or until the Clinic changes its services and asks me to sign a new one.

[Signature of Patient/Parent/Legal Guardian/Patient Advocate/Durable Power of Attorney

Print Name of Person Signing if other than adult patient

Date/Time: _____

[Signature of Witness]

Print Name of Witness:

Date/Time: _____

**Sign Language Interpreter to complete when applicable:**

I have accurately and completely signed the foregoing document to:

[Insert the Patient's or Patient's Guardian/Legal Representative's name]

She/he understood all of the terms and conditions and acknowledged his/her agreement and consent thereto by signing the document in my presence.

[Signature of Interpreter]

Print Name of Interpreter

Date/Time: _____

*If Pacific Interpreters Service was used (phone interpretation service) list the name of the interpreter providing the service.*

Name of Interpreter providing interpretation service