

Consent to Treat

Patient Name: _____

DOB: _____

Consent to Treatment

The undersigned consents to health care encompassing routine diagnostic procedures, medical treatment, and the rendering of such professional services by or under the supervision of licensed physicians and practitioners employed by or on the medical staff of PulmoCrit Associates as are necessary or advisable for my diagnosis and treatment.

No Guarantees

It is understood that the practice of medicine, surgery and the rendering of health care is not an exact science and no guarantees have been made to the patient concerning the results of examination or treatment.

Release of Information

The undersigned agrees that, to the extent necessary to determine liability of payment and to obtain reimbursement, PulmoCrit Associates may disclose portions of the patient's medical record to appropriate persons or organizations.

Assignment of Insurance Benefits

The undersigned authorizes direct payment to PulmoCrit Associates of the insurance benefits otherwise payable to or on behalf of the patient for services rendered, and authorizes the use of this signature on all insurance submissions.

Certification

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient or is duly authorized by the patient as the patient's legal representative to execute the above and accept its terms.

Patient Signature / Legal Representative

Date

Printed Name

Relationship to Patient (if not patient)