Patel
MEDICAL ESTHETICS
& FAMILY DENTISTRY
Your one-stop shop for affordable family healthcare

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CONSENT/AUTHORIZATION FORM

NAMED DOCTOR/S ____

CONSENT FOR TREATMENT

I authorize the above –named doctor/s to perform the treatment/procedure/s described below. I have been informed of the reasons for the treatment/procedures/s, along with the expected benefits, risks, possible alternative methods of treatment and possible consequences involved in the following:

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The treatment/procedure/s was explained to me in detail and all my questions were fully answered. Understanding this, I authorize the above-named doctor/s to perform such examinations, treatments, laboratory tests and to administer such medications as, in his or her opinion, are necessary or advisable for me (or ____.)
Name of patient if minor

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.

INSURANCE AUTHORIZATION

I request that payment of authorized benefits be made to the above-named doctor/s on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any third party payer, state medical assistance agency or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of the authorization to be used in place of the original.

____ ______________________________

Signature *(Patient or person authorized to consent for patient)* Date