Consent to Treat Form

Patient: _____ DOB: _____

Permission to Treat:

I hereby consent to treatment by Geriatric Post-Acute Specialists physicians and other professional healthcare providers, Advanced Practice Nurse Practitioners ("APRN") and physician assistants ("PA's") to provide and perform such medical care, tests, procedures and other services that are deemed necessary or beneficial by the Practice for my health and well-being. I consent to treatment with the understanding that I retain the right to consent and/or refuse individual treatments and recommendations from such providers. The Geriatric Post-Acute Specialists physicians and other professional healthcare providers are hereby engaged by me as my healthcare providers in a non-exclusive relationship.

Authorization of Payment of Insurance Benefits: I authorize payment to Geriatric Post-Acute Specialists of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I hereby authorize the release of any/all medical records about me for the purposes of payment to the services rendered to me.

Financial Agreement. I agree that in consideration of the services rendered to me, to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Practice. I understand that to the extent permitted by law, where insurance or other third-party benefits are insufficient to pay for all of the services rendered, that I will be responsible for the payment of any balances due as determined by the respective provider of services, including deductibles, copayments, co-insurance or other fees required by insurer, HMO or other benefit plan. I understand that if I have not provided the Practice with accurate and current information regarding my insurer at the time of service, HMO or other beneficiary/third party payor which provides me with health care coverage, I will be personally responsible for the cost of all care rendered by the Practice. I agree to pay all bills when presented.

_____ _____

Signature of patient or legal representative Date

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Relationship to patient if legal representative