Medical Consent to Treat

Patient Legal First Name	Patient Legal Last Name	Suffix	Middle Initial

Date of Birth	Social Security Number	Phone Number

I hereby elect Florida Interventional Pain Clinic to manage my medical needs.

My signature below authorizes Florida Interventional Pain Clinic DBA Elyaman Medical Services:

Conduct any assessments, diagnostic examinations and/or tests deemed necessary/beneficial throughout the course of their involvement with my ongoing care.

Provide treatment(s) and order/prescribe medication(s), medical equipment, therapy, and any other medical services and/or interventions needed to effectively maintain my health, including any current and/or acquired diagnosis, illness, or injury.

Obtain all past and present medical records including physician notes, medications, hospitalizations, procedures, and/or diagnostic results as needed for continuity of care.

Furthermore, I authorize payment for services to Elyaman Medical Services along with the release of any medical information necessary for the processing of claims arising from my medical care and I authorize permission to Absolute Elder Care to bill Medicare and any/all supplemental insurances/ coinsurances; including non-covered services. I also agree to pay all charges in full if I become a member of an HMO or out of network health insurance plan under which services provided by Absolute Elder Care are no longer covered.

Signed by: ☐ Patient ☐ Legally Authorized Representative of Patient

Patient or Legal Representative Signature **Date Signed**

Legal Representative Printed Name & Legal Designation Granting Authority to Sign on Behalf of Patient