ALL AMERICAN FAMILY & GERIATRIC CARE, PLLC

CONSENT TO TREAT

I, the undersigned voluntarily give consent to my All American Family and Geriatric Care medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ _____

Signature of patient/legal representative **Date**

. . . . . .

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of the All American Family and Geriatric Care Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ _____

Signature of Patient/Legal Representative **Date**

. . . . . .

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

. . . . . .

AUTHORIZATION AND ASSIGNMENT

I hereby authorize my All American Family and Geriatric Care practice location to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to All American Family and Geriatric Care (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Legal Representative **Date**