



CONSENT TO TREATMENT

I, _____, authorize Amos O. Dare, M.D. to perform medical treatment.

I authorize any physician, medical practitioner, hospital or other medical facility, peer review organization, insurance company, the Healthcare Financing Administration, the Medical Information Bureau, Inc., employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me.

I understand the information obtained by **Palm Beach Brain & Spine** will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to the persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. Please be advised that your medical history is strictly confidential. Absolutely NO information will be released without proper legal consent, unless deemed by laws of the state of Florida.

Signature of Patient/Guardian

Date

PAYMENT OF BENEFITS

I authorize that payment of medical benefits be made to Amos O. Dare, M.D. on any claim submitted for any services furnished by Amos O. Dare, M.D.

I understand that I am financially responsible to Amos O. Dare, M.D. for any portion of the charges for my care not covered by my insurance.

Signature of Patient/Guardian

Date