INTEGRA
Rehabilitation Physicians

Consent/Authorization for Treatment

Patient Name: _____ Date of Birth: _____

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical conditions may render the patient susceptible for injury. The doctor of course, will not provide specific healthcare, if he/she is aware that any such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological conditions which would otherwise not come to the attention of the physician.

_____(initial) I authorize the electronic access of my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I have read the foregoing and understand it;

Patient Signature: _____ Date: _____

Print Name of Parent/Guardian: _____Relation: _____

Signature of Parent/Guardian: _____

Authorization to Consent to Healthcare for Minor

I am the guardian having legal custody of the above named minor child. I hereby give authorization for the physicians at Integra Rehabilitation Physicians to provide healthcare services to my minor child in my absence.

This consent shall be effective from the date of its executed until the date I terminate it in writing. By signing here I indicate that (i) I have the understanding and capacity to recognize the importance of, to communicate, and assign the healthcare decisions covered by this document, (ii) I am fully informed as to the contents of this document, and (iii) I fully understand the full scope and importance of this grant to Integra Rehabilitation Physicians.

Print Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____