Eisenman & Eisenman, M.D., LLC

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Lake Worth, Florida 33449
Phone: 561-753-7487 Fax: 561-753-8161

PATIENT CONSENT FOR TREATMENT

I, _____, understand that as part of my health care, Eisenman & Eisenman, M.D., LLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for the future care or treatment.

TREATMENT CONSENT: I hereby give consent to Eisenman & Eisenman, M.D. LLC to examine, treat and perform diagnostic tests and office procedures that the provider deems necessary. I authorize you to view my prescription history from external sources in order to facilitate appropriate medication orders and reconciliation. In understand that communication between interdisciplinary healthcare providers is a necessity for quality of care and information may be requested from other providers that I have seen.

REASON OF RESPONSIBILITY: I understand that if I leave the practice without the consent of the physician and/or fail to carry out instructions for follow-up care: I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from Eisenman & Eisenman, M.D., LLC will be my responsibility.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

_____ _____

PRINTED NAME OF PATIENT DATE

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SIGNATURE OF PATIENT