

# Consent to Treat

PulmoCrit Associates • (844) 428-5864 • pulmocrit.com

**Patient Name:**

**Date of Birth:**

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## Consent to Treatment:

The undersigned consents to health care encompassing routine diagnostic procedures, medical treatment and other health services, rendered to the patient.

## No Guarantees:

It is understood that the practice of medicine, surgery and the rendering of health care is not an exact science and that no guarantees have been made as to the end results of treatment, examination, or other health services rendered by the healthcare providers and staff at PulmoCrit Associates Inc.

## Release of Information:

The undersigned agrees that, to the extent necessary to determine liability of payment and to obtain reimbursement, PulmoCrit Associates Inc. may disclose portions of the patient's records, including medical records, to any person or entity which is or may be liable for all or part of the payment to PulmoCrit Associates Inc. charges.

## Assignment of Insurance Benefits:

The undersigned authorizes direct payment to PulmoCrit Associates, Inc. of benefits otherwise payable to or on behalf of the undersigned for treatment and health services rendered, at a rate not to exceed PulmoCrit Associates, Inc. regular charges. Payment to PulmoCrit Associates, Inc. pursuant to this authorization, by an insurance company shall discharge said insurance company of all obligations under the policy to the extent of such payment.

## Certification:

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or a duly authorized agent of the patient to execute this agreement and accept its terms.

**Patient Signature /  
Legal  
Representative:**

**Date:**

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