Patient Name: _____
(Print)

CONSENT TO SERVICES AND TREATMENT

At each new year you will be asked to sign a new Consent to Services.

- CONSENT TO SERVICES AND TREATMENT initials_____

I authorize the licensed doctor and whomever he/she designates to perform diagnostics, therapeutic procedures and administer care as medically needed.

- CONSENT TO TREATMENT OF A MINOR initials_____

I authorize the licensed doctor and whomever he/she designates to perform diagnostics, therapeutic procedures and administer care as medically needed

to _____, my _____.
Minors Name Relationship to Minor

- FEMALE PATIENTS initials_____

This certifies that to the best of my knowledge that I am NOT PREGNANT. I authorize Pro Neuro Health to take x-rays as medically needed. Beginning date of your last menstrual cycle:_____

Signature (patient or guarantor):_____ Date:_____

CONSENT TO CONTACT

Please write down the names of any person(s) that we are able to communicate with regarding general issues, *non-medical in nature* including anyone in the household or at work able to retrieve messages left on answering machine, retrieve mail, answer the phone on your behalf or schedule your appointments, etc.).

_____ _____

_____ _____

_____ _____

This authorization is irrevocable until request of change is submitted in writing to PRO NEURO HEALTH.

_____ _____ _____
Patient Name (Printed) Patient or Responsible Party (Signature) Date

I authorize Pro Neuro Health and its authorized representatives, to *discuss my care-medical in nature* with the following:

I authorize Pro Neuro Health and its authorized representatives to request and / or release *medical records* to / or from the following:

_____ _____

_____ _____

_____ _____

This authorization is irrevocable until request of change is submitted in writing to Pro Neuro Health

_____ _____ _____
Patient Name (Printed) Patient or Responsible Party (Signature) Date