SPI
Where the Patient's Interest, Is the Only Interest

Consent to Treat

I authorize the Physicians of Spine Physicians Institute to provide me with reasonable and proper medical care according to today's standards. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

DISCLOSURE:

Patient contact Information:

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Emergency Contact Name(s): _____

Relationship: _____ Phone: _____

Do you give consent for Spine Physicians Institute staff to leave a message with pertinent medical information at the provided phone numbers?
YES NO

Do you give consent for Spine Physicians Institute staff and/or your physician to discuss your medical condition with this person(s) if needed?
YES NO

Printed Name: _____

Signature: _____ Date: _____

COBRA PATIENTS:

Cobra patients must provide documentation of active coverage on a month-to-month basis provided by employer.

I _____ am currently on a Cobra plan through my employer and am aware that I am responsible for verification of coverage. In the event that I am unable to provide the necessary documentation and my coverage is not valid, I understand that I am personally responsible for all charges incurred at the time services are rendered.

Signature: _____ Date: _____