Patient Name: _____

CONSENT TO TREAT

I, the undersigned voluntarily give consent to Rajani Medical Group, LLC to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ _____

Signature of patient/legal representative **Date**

. . . . . .

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of the Privacy Practices and the Florida Patient Bill of Rights for Rajani Medical Group, LLC.

_____ _____

Signature of Patient/Legal Representative **Date**

. . . . . .

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

. . . . . .

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Rajani Medical Group, LLC to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Rajani Medical Group, LLC for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Legal Representative **Date**

. . . . . .

I, the undersigned voluntarily give consent to Rajani Medical Group, LLC and it's providers to obtain prescription history from external providers to assist in my care. Rajani Medical Group, LLC providers may view my external prescription history and see prescription information from other prescribers.

_____ _____

Signature of patient/legal representative **Date**