CONSENT FOR MEDICAL TREATMENT (Patients and Patients Representative)

Patients Name:________________________________, or representative___________________________; have allowed Nurse Practitioner Florence Bamgbose, located at GenerationSpan Healthcare, LLC to provide primary medical care service which includes (physical exams, lab, biopsy, incision and drainage, administration of medication and all medical treatment and counseling) necessary to promote my quality of life. In addition, I also give the practice permission to obtain or transfer medical records to any vendors such as specialist, third party payers, others vendors involved in my medical care. I allow the practitioner to contact me at the number __________________or email address________________________. I f I am not able to be reached they may also contact me at ________________________. It is okay to leave a message at ________________________________. They may also mail my medical information to _____________________________. (If not, write No at the line).

I give Medicare/MEDICAID or any such entity otherwise known as, “Third Party Payers” to provide direct payment to GenerationSpan Healthcare. I acknowledge that any remaining payment not paid by my insurance will be billed to me and must be paid at or within 30 days. If payment is not received, the bill will be sent to collection.

Request for form completions, to include: Will be charged upon completion $15 to $20. Please give the office 7 days to complete. If possible document submitted may be completed sooner.

Disability forms

FLA (Family leave of Absence form)

Letters

Completion of other administrative form

I understand that medicine is not an exact science, and that the nurse practitioner will provide me with treatment based on guidelines and common knowledge. I as a patient must communicate and participate in my treatment.

Signature: Patient:_______________________________________

Date:_______________________________________