COUNTRYSIDE MEDICAL

7860 SW 103rd St. Rd.
Bldg. 100, Ste. 101
Ocala, Florida 34476
(352) 873-4458
Fax (352) 873-8116

CONSENT TO TREAT

I hereby give consent to Countryside Medical to provide whatever treatment they may deem necessary to the patient. I understand that refusal of any treatment recommended by Countryside Medical must have a signature.

I hereby authorize lifetime release of any medical records and other information, as required, or may be required, for the payment of benefits payable by insurance or other third-party sources of payment, in connection with the treatment of the below-named patient, and I further authorize payment directly to Countryside Medical of any and all benefits payable arising from any insurance or other source, and which are otherwise payable to me.

I HAVE READ AND FULLY UNDERSTAND THE CONTENT OF ALL PAGES OF THIS PATIENT INFORMATION AND MEDICAL RELEASE FORMS. I HAVE READ THE FINANCIAL POLICY, I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

Signature Patient Authorization Date

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Mastercard, or payment by cash or check at time service have been verified.

I,_____ being the legal guardian of this minor,_____
Pts Name
hereby authorize the treatment of this patient by Countryside Medical Staff.

I HAVE READ AND FULLY UNDERSTAND THE CONTENT OF ALL PAGES OF THIS PATIENT INFORMATION AND MEDICAL RELEASE FORMS. I HAVE READ THE FINANCIAL POLICY, I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

Signature of Responsible Person Date

Method of Payment: ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

NOTE: RETURN CHECK FEE OF $20.00 FOR EACH RETURNED CHECK.
MISSED APPOINTMENTS ARE CHARGED $25.00.