FLORIDA AUDIOLOGY ASSOCIATES

CONSENT TO TREAT

1. I _____ (print name) give permission for Florida Audiology Associates to provide me medical treatment as outlined within the scope of practice by the rendering provider.

2. I allow Florida Audiology Associates to file for insurance benefits to pay for the care I receive. In doing so, I understand the following:

- Florida Audiology Associates may have to send my medical record information to my insurance company. _____ (initial)
- I must pay my share of costs not covered by insurance. _____ (initial)
- Self-pay patients must pay for services in full at the time of visit.

3. I understand that I have the right to refuse any procedure or treatment as well as the right to discuss all medical treatments with my clinician._____ (initial)

_____
Printed name

_____
Signature

_____
Relationship to patient

_____
Date