

4714 NORTH ARMENIA AVE, SUITE 200
TAMPA, FL 33603
(813) 872-8794
(813) 879-1652 FAX
(813) 998-0121 FAX

4655 KEYSVILLE AVE.
SPRINGHILL, FL 34608
(352) 688-0800
(352) 688-0468 FAX

SANFORD R. DOLGIN, M.D.
KEVIN J. DONNELLY, M.D.
DEAN G. DAVIS, M.D.
DANIEL A. VINCENT, JR., M.D.
SCOTT R. ANDERSON, M.D.

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by **DOCTORS DOLGIN, DONNELLY, DAVIS, VINCENT, AND ANDERSON** deemed advisable and necessary in the diagnosis and treatment of my condition. 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. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by **DOCTORS DOLGIN, DONNELLY, DAVIS, VINCENT, AND ANDERSON** I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize **DOCTORS DOLGIN, DONNELLY, DAVIS, VINCENT, AND ANDERSON** to furnish information to CMS/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related service. I hereby authorize (assign) my Insurance Carrier(s)/CMS to make payment directly to **DOCTORS DOLGIN, DONNELLY, DAVIS, VINCENT, AND ANDERSON** for medical/diagnostic surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that CMS and/or other insurance carriers do not cover all office services/procedures. **I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services rendered.** I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature: _____ Date: _____

DESIGNATED RELATIVE

I Authorize Discussion and release of My General Medical Condition and Diagnosis (including treatment, payment and health care operations) with: () Spouse () Children () Other _____

Please list the family members or significant others, if any whom We May Inform about Your Medical Condition, and/or in Case of an Emergency:

Name: _____	Relationship: _____	Phone Number: _____
Name: _____	Relationship: _____	Phone Number: _____
Name: _____	Relationship: _____	Phone Number: _____
Name: _____	Relationship: _____	Phone Number: _____

Messages May be Left on My Answering Machine Regarding My Health & Appointments Made: Yes No

Signature: _____ Date: _____