METABOLIC
CENTER *for* WELLNESS

Name_____ DOB _____

CONSENT FOR EVALUATION OR TREATMENT

The undersigned person hereby consents to the evaluation or treatment that the assigned healthcare provider may deem necessary to the patient named above.

_____ _____

PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Metabolic Center for Wellness, P.A., I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

PATIENT SIGNATURE DATE

FOR MEDICARE PATIENTS ONLY

LIFETIME MEDICARE PART B SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.

_____ _____

PATIENT NAME (PRINTED) DATE

_____ _____

PATIENT SIGNATURE DATE

_____ _____

MEDICARE B# DATE