AUTHORIZATION TO TREAT AND BILL

I acknowledge receipt of Geriatric Solutions' Notice of Privacy Practices, Notice of Health Information Practices, and the Patient and Family Bill of Rights. Copies are available on the Geriatric Solutions website and I may request additional copies if needed.

I hereby consent to evaluation and treatment as directed by my Geriatric Solutions Medical Provider or his/her designee. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified on this form. I authorize Geriatric Solutions to bill my medical insurances for the care I receive and to release any information the insurance carrier requires to process a bill.

Patient Name (printed) _____ Date _____

Patient Signature _____ Date _____

Patient Representatitve/MPOA Signature _____ Date_____
(if applicable)

GERIATRIC
SOLUTIONS
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