MICHAEL E. BUXBAUM, D.O. P.A.

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, as the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments and transfers to other facilities considered necessary or advisable in the judgment of the attending physician, his/her assistants or designee. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed in this facility. I authorize MICHAEL E. BUXBAUM, D.O. P.A. or members of its attending staff to retain me and I certify by my signature that I understand and accept its contents, except as noted.

_____

Patient Name (Print) Date of Birth

_____

Patient/Responsible Party Signature Date

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I understand that my protected health information will be used by MICHAEL E. BUXBAUM D.O. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. I understand that I may request a restriction on the use or disclosure of my protected health information. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. I understand that MICHAEL E. BUXBAUM D.O. reserves the right to modify the privacy practices outlined in this notice.

_____

Patient Name (Print) Date of Birth

_____

Patient/Responsible Party Signature Date

Internal Use Only

If the patient/patient's representative refuses to sign this acknowledgement, please document date and time the Notice of Privacy Practices were presented to the patient and sign below.

Presented (date and time): _____

By (name/title):_____