Brian D. Kurland, MD., F.A.C.S ® Eileen C. de Grandis, MD

CONSENT TO EXAMINATION, TREATMENT AND STATEMENT OF FINANCIAL POLICY AND RESPONSIBILITY.

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1. **By my signature below,** I attest that I am capable of reading and comprehending this form without assistance, and have signed the form on my own free will. I agree that I have been made aware of the availability of assistance and/or an interpreter to help me in completing this form, and declined any aid.
2. **By my signature below,** I hereby authorize the physician, with the assistance of other health care providers and assistants by him/her, to do:
   a. General routine examination
   b. Perform the diagnostic procedures listed below, and/or
   c. Provide the care, treatment, therapy or remedy listed below, after informing me of the risks, benefits, and alternatives, as well as answering any questions that I may have.
   d. Explain the risks of NOT having the examination/diagnostic procedure/treatment proposed.
3. **By my signature below,** I further agree to undergo any examinations, x-rays, blood tests and/or any other diagnostic modalities that the doctor may determine to be important and/or relevant to my care.
4. **By my signature below,** I agree that the doctor will explain my medical condition(s), symptom(s), or illness, if known, and will explain any proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. **I agree to ask for clarification if needed.**
5. **By my signature below,** I agree that I can ask questions and raise concerns with the doctor about my condition, the risks inherent to the examination, diagnostic procedure, and/or treatment, and that I may stop treatment at any time for clarification of treatment options.

6. **By my signature below,** I attest that I have stated or noted my past medical history to the best of my ability, and further attest that I have not taken any undisclosed medications or drugs prior to examination and/or treatment.
7. **By my signature below,** I agree that the doctor or any individual employed by the physician has not provided guarantee or assurance that the examination, diagnostic procedure, and/or care, treatment, therapy or remedy will cure or improve the condition(s) listed above. I further understand that the examination, diagnostic procedure, and/or care, treatment, or therapy may make it worse.

8. **By my signature below,** I agree that, as part of the examination, diagnostic procedure, and/or care, treatment, therapy, or remedy provided, the doctor may obtain certain protected health information, including past medical history. I understand the information sought may include, but is not limited to the following:
   i. Records of physical exams and procedures
   ii. Laboratory, x-ray, MRI, and other test results
   iii. Record medication or drug abuse
   iv. Records of implanted or external medical devices
   v. Information related to diagnosis and treatment of mental health condition
   vi. Information about HIV/AIDS
   vii. Information about hepatitis infection
   viii. Information about sexually transmitted diseases
   ix. Information about infectious diseases that must be reported to the Public Health authorities.

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9. **By my signature below,** I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida Law imposes strict penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that the physician listed above has elected, pursuant to Florida Law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida Law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida Law.
10. **By my signature below,** I understand and agree to pay all deductibles, co-payment, and fees due. If I am unable to pay for treatment previously rendered, I agree to timely notify the doctor in an effort to arrange a mutually acceptable repayment plan. I agree that if I fail to notify the doctor, or if I fail to pay any agreed installments, I will be responsible for payment of all amounts due, including but not limited to, the costs of collection and legal fees.
11. **By my signature below,** I hereby certify that I have read and fully understand all of the words and information contained in this form, and reaffirm my consent to the examination, diagnostic procedure, and/or care, treatment, therapy, or remedy proposed, if I agree after the discussion of each individual test.

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Signature of Patient, Guardian or Personal Representative

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Signature of Patient, Guardian or Personal Representative

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Print name of Patient, Guardian or Personal Representative

______________________ ______________________

Date Relationship to Patient

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