Bishnu P. Verma, M.D., P.A.

Internal Medicine **Diplomate ABIM in Internal Medicine**

American College of Physicians
Internal Medicine/Doctors for Adults

AUTHORIZATION FOR ROUTINE DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT

Patient Name _____

I, THE UNDERSIGNED PATIENT, PARENT, OR LEGAL GUARDIAN, KNOWING THAT I AM/THE PATIENT IS SUFFERING FROM A CONDITION REQUIRING MEDICAL CARE, DO HEREBY CONSENT TO SUCH MEDICAL CARE ENCOMPASSING ROUTINE DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT BY BISHNU P. VERMA,M.D. I ACKNOWLEDGE THAT NO GUARNTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF TREATMENT OR EXAMINATION.

Patient Signature _____

Patient Representative _____

Relationship to Patient _____

Date _____

I ACKNOWLEDGE THAT I DO DO NOT HAVE MEDICARE COVERAGE. (IF I DO HAVE
(Circle One)

COVERAGE,THAN I WILL PROVIDE A COPY OF MEDICARE CARE). **INITIALS**_____

1555 Saxon Boulevard, Suite 601, Deltona, FL 32725, Telephone (386) 860-2600, Fax (386) 860-7216