Miami Beach Community Health Center, Inc.

710 Alton Road, Miami Beach, FL 33139
1221 71st Street, Miami Beach, FL 33141
Tel: (305) 538-8835
S. Fax: (305) 532-5766 N Fax: (305) 865-1881

AGREEMENT FOR TREATMENT

1. I hearby consent to and authorize this facility, the staff and physicians to conduct and tests, examinations and treatments which, in their judgment become necessary or advisable in the diagnosis and treatment of'

   Patient's Name: _____

2. I have received a copy of the Patient Bill of Rights statement. These have been explained to me by:

   Name:_____

3. I further authorize the staff and administration of this facility to institute any emergency procedures which they deem necessary. I consent to transfer to another facility if the emergency warrants such transfer.

4. 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 a result of treatment.

5. I hereby release the Miami Beach community Health Center the medical staff, nurses and employees from any and all liability whatsoever fro this course of treatment, I further understand that this release shall be binding upon:

   Name of Patient:_____ his /her heirs, executors administrator and assignees.

6. I hereby authorize payment directly to the Miami Beach community Health Center, Inc. of benefits due to me in my pending claim for general medical and/or major medical benefits otherwise payable to me, but not to exceed the health center and/or physician's regular charges for this period or treatment. I agree that a photo-static copy of this authorization is as valid as the original.

7. I understand that MIAMI BEACH COMMUNITY HEALTH CENTER, INC. uses Physicians Assistants (means a person who is a graduate that meets standards approved by the boards and is licensed to perform medial services delegated by the supervising physician) and Advances Registered Nurse Practitioners (means, that is addition to the practice of professional nursing, the advanced-level nursing acts approved by the boards are proper to be performed under the general supervision of a licensed practitioner) to provide medical services to their patients. I understand that the need may arise to use mid-level practitioners, as mentioned, for medical services and I have no objection as to the use of Physicians Assistants and Advanced Registered Nurse Practitioners for any of my medical services.

By my signature affixed below, I certify that I understand the contents and ramifications of this form which I have read or had read to me.

COMMENTS:_____

_____

_____

_____	_____	_____
Witness	Date	Signature of patient or responsible party and relationship to patient.